



MCMXXV

STYLE OF
CASE : IN RE:

[REDACTED]

PERTAIN TO :

FROM : Joshua Tree Physical Therapy/ Dr. Kevin Sigroi, M.D. (Medical Records)

DELIVER TO : Christina Ctorides
Goldsmith Ctorides & Rodriguez, LLP.
140 Sylvan Avenue, 3rd Floor
Englewood Cliffs, NJ 07632

CASE NO.:

COURT:

Order No. 102305.001

STATUS

Pending Legals

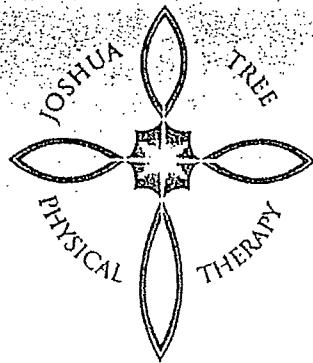
Please be advised that we are currently attempting to obtain the appropriate legals from the custodian for this facility.

The records turned over by the custodian are available for online viewing.

Do not hesitate to contact our office with any questions or concerns regarding this matter.

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JOSHUA TREE PHYSICAL THERAPY

Initial Evaluation

Date: March 17th, 2009.

Physician: Dr. Wescott.

Re: [REDACTED]

Diagnosis: Low back pain/hip pain.

Dear Wescott:

Thank you for referring your patient to Joshua Tree Physical Therapy. Upon initial evaluation the following was determined.

History: Patient is a [REDACTED] female with complaints of cervical spine pain, upper thoracic pain, mid back pain, and low back pain. Patient also complains of frequent headaches throughout the day. Patient's mother was present upon intake of information and verified what her daughter had stated. Patient's headaches and back pain are worse in the morning and does occasionally wake the patient from her sleep at night.

PMH: Patient has been diagnosed with Chiari. Patient has undergone several surgical procedures secondary to this diagnosis. There has been a duraplasty patch surgically implanted at the base of the child's skull. She also has a lumbar shunt to enhance the flow of cerebral spinal fluid. Patient also had surgery for removal of vertebrae C1 and L3 through L5. Patient also has been diagnosed with hypercalcemic production and is taking medication HCTC for this condition.

Objective:

Active Range of Motion

Loss of Movement:

Lumbar flexion:	Moderate with severe complaints of low back pain
Lumbar extension:	Minimal with complaints of low back pain pain.
Lateral flexion left:	Minimal with complaints of tightness and pulling
Lateral flexion right:	Minimal with complaints of tightness and pulling
Rotation right:	None.
Rotation left:	None

Manual Muscle Test:

Left

Right.

Quadriceps:	4+/5	4+/5
Hamstrings:	4+/5	4+/5
Ankle plantarflexion:	4+/5	4+/5
Dorsiflexion:	4+/5	4+/5
Dorsi flexion great toe:	4+/5	4+/5

Objective:

AROM.

Left

Right.

Cervical flexion:	75 % of normal	
Cervical extension:	90 % of normal.	
Lateral flexion:	80 %	80%.
Rotation:	90 %	90%.
Shoulder AROM: (flexion)	180°	180 °

8475 NORTH GOVERNMENT WAY, HAYDEN, IDAHO 83815

PHONE: 208-772-9774 FAX: 208-772-9564

Palpation: There are noted numerous trigger points and tonic muscle spasms throughout the cervical, thoracic, and lumbar paraspinals.

Treatment Program: The patient will receive education on proper body mechanics and posture. Treatment and modalities will include, anodyne light treatment, medical massage, neuromuscular reeducation, therapeutic laser, therapeutic exercises, and home exercise program.

Assessment:

Problem List:

- Complaints of pain at rest.
- Complaints of pain with activities of daily living.
- Tonic muscle spasms noted throughout all paraspinals.
- Decreased active range of motion cervical spine and lumbar spine.
- Complaints of constant headaches

Short-Term Goals: Four weeks

- Decrease complaints of pain at rest by 50%.
- Decrease tonic muscle spasms by 50%.
- Increase active range of motion cervical and lumbar spine to WNL.

Long-term goals: Eight weeks.

- Decrease complaints of pain at rest to 0/10.
- Patient to perform activity daily living without complaints of pain.
- Decrease tonic muscle spasms by 90%.
- Patient to be independent with supervision in home exercise program.

Plan of Care: The patient will receive the above treatment program two to three times a week for up to eight weeks. The treatment program will be upgraded and modified as per physician's recommendations and as patient tolerates to achieve the above goals.

Once, again thank you for referring your patient to Joshua Tree Physical Therapy. If you have any questions or recommendations about your patient's care please contact me at your earliest convenience.

Respectfully,



Kevin J. Sgroi, RPT

03/18/2009 8:03 AM

Patient Report By Patient Number
LAKESIDE PEDIATRIC & ADOLESCENT MEDICINE

Page 1

Selections:

Registered: 01/01/1990 - 03/18/2009
 Patients: [REDACTED]
 Accounts: 640
 Alerts: Excluded
 Notes: Excluded
 Deactivated: Included

806	[REDACTED]	Default Account: 640 2417 E St James Hayden, ID 83835 Email: Home: Work: (208) 762-5619	SSN: [REDACTED] Chart #: [REDACTED] Registered: 10/09/2007 First Visit: 10/09/2007 Last Visit: 02/20/2009 Consent: Yes Referral Src: [REDACTED]	Class: [REDACTED] Sex: Female DOB: [REDACTED] Race: C Lang: ENG Marital: Single Assigned: Westcott, MD, Ronda L. Referring: [REDACTED]	Emp Status: U Employee ID: [REDACTED] Employer: [REDACTED]																																							
Emergency Contact: Bryant, Caren Pat Rel to Contact: Grandchild																																												
Legal Guardian: Bryant, April Pat Rel to Guardian: Child																																												
<p>Accounts:</p> <table border="1"> <thead> <tr> <th>Number</th> <th>Guarantor</th> <th>Acct Finance Grp</th> <th>Default</th> <th>Status</th> <th>Balance</th> </tr> </thead> <tbody> <tr> <td>640</td> <td>Bryant, Wayne</td> <td>STNCKD</td> <td>Y</td> <td>Active</td> <td>0.00</td> </tr> </tbody> </table> <p>Ins. Policies:</p> <table border="1"> <thead> <tr> <th>Plan</th> <th>Group</th> <th>Claim Member ID#</th> <th>Status</th> <th>Subscriber</th> <th>Relation to Sub</th> <th>Accept Assign</th> </tr> </thead> <tbody> <tr> <td>1 BC01 - Blue Cross of Idaho</td> <td>16021080</td> <td>XNP070191763</td> <td>Active</td> <td>Bryant, Wayne</td> <td>Child</td> <td>Y</td> </tr> <tr> <td>2 MC001 - Medicaid</td> <td></td> <td>1643066</td> <td>Active</td> <td>[REDACTED]</td> <td>Self</td> <td>Y</td> </tr> </tbody> </table> <p>Extended Info:</p> <table border="1"> <thead> <tr> <th>Description</th> <th>Value</th> </tr> </thead> <tbody> <tr> <td>Dad's Nickname</td> <td>Wayne Bryant</td> </tr> <tr> <td>Mom's Nickname</td> <td>April Bryant</td> </tr> </tbody> </table>						Number	Guarantor	Acct Finance Grp	Default	Status	Balance	640	Bryant, Wayne	STNCKD	Y	Active	0.00	Plan	Group	Claim Member ID#	Status	Subscriber	Relation to Sub	Accept Assign	1 BC01 - Blue Cross of Idaho	16021080	XNP070191763	Active	Bryant, Wayne	Child	Y	2 MC001 - Medicaid		1643066	Active	[REDACTED]	Self	Y	Description	Value	Dad's Nickname	Wayne Bryant	Mom's Nickname	April Bryant
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Description	Value																																											
Dad's Nickname	Wayne Bryant																																											
Mom's Nickname	April Bryant																																											

Total Patients: 1

03/18/2009 MED 3:10 PM 208 292 541 LAKESIDE PEDIATRIC

2003/003



980 W. Ironwood Dr. Suite 302
Coeur D' Alene, ID 83814

Jean M. Prince, M.D. Ronda L. Westcott, M.D.
Brian J. Hickok, M.D. Jennifer Torok, NP-C
Laine Hughes, FNP
Phone (208)292-5437 Fax (208)416-0170

To: Joshua Tree, P.T.

Attention: _____

Fax number: 772-9564

Date: 3/18 Total Pages Sent: _____

From: PCP

RE: *Chart notes have completed
list, I will fax ASAP! *
THANKS.

Confidentiality Note

Unless otherwise indicated or obvious from nature of this transmission, this information contained in the facsimile message is confidential information, intended for the use of the individual or entity named above. If the reader of this message is not the intended recipient or the employee or agent responsible, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, or are not sure whether it is confidential, please immediately notify us by telephone or return the original message to us at the above address, via U.S. Postal Service at our expense. Thank you.

REFERRAL REQUEST

Lakeside Pediatric & Adolescent Medicine, PLLC
980 W. Ironwood Drive, Suite 302
Coeur d' Alene, Idaho 83814
Phone (208) 292-5437 Fax (208) 292-5441

Referring Provider: Ronda Westcott, MD

Patient Name: [REDACTED] Age: [REDACTED] D.O.B.: [REDACTED]

Parent/Guardian Name: Wayne Bryant

Home Phone #: 208-762-5619

Insurance Policy Holder: Bryant, Wayne

Insurance Carrier: Blue Cross of Idaho / Medicaid

Insurance ID #: XMP970191763 / 1643066 Group #: 10021090

Authorization #: 806 389 000

Referred To: Joshua Tree Physiatry

Phone Number: 772-9774 Fax Number: 772-9561

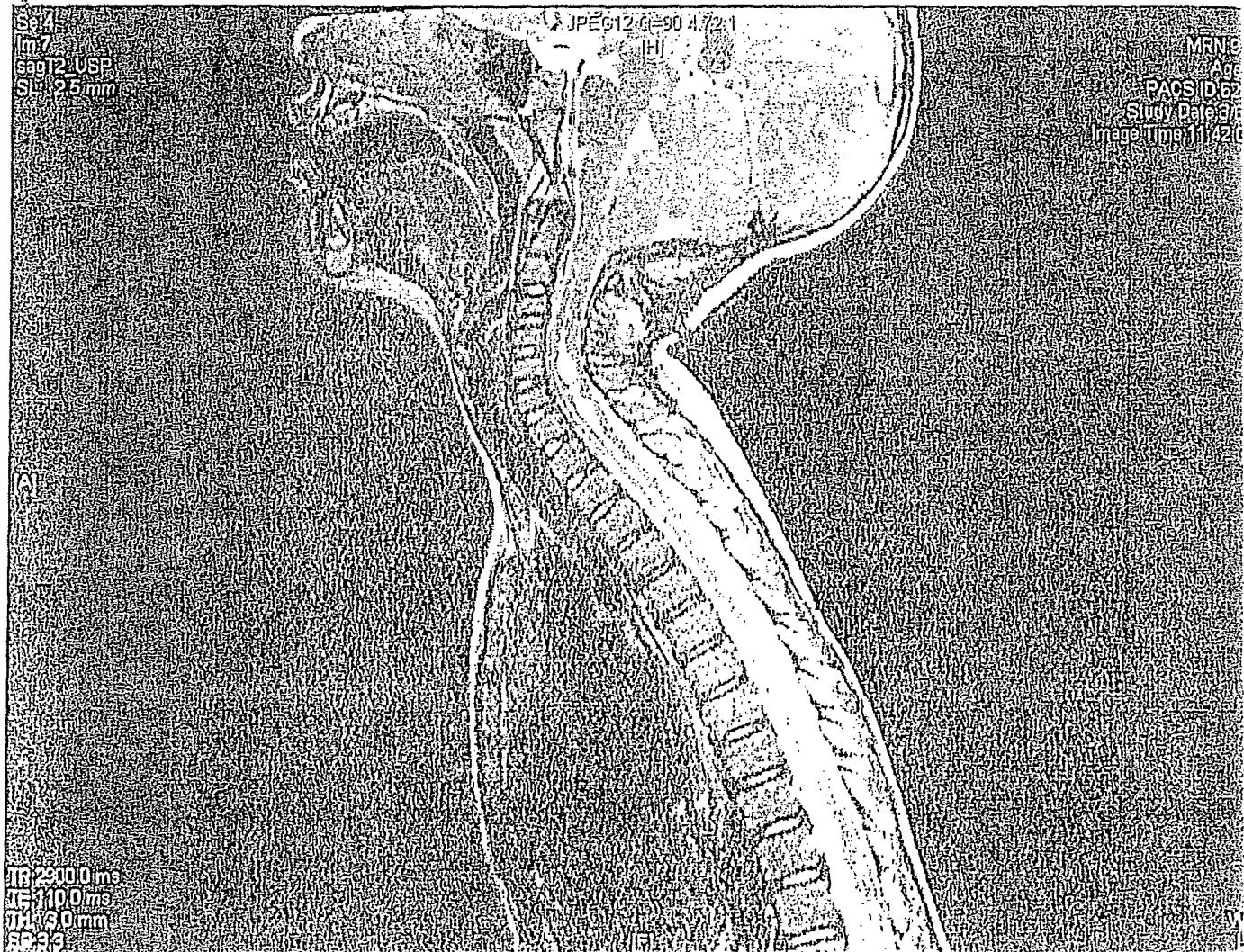
DIAGNOSIS: Chiari, muscle spasms, headache and decreased ROM

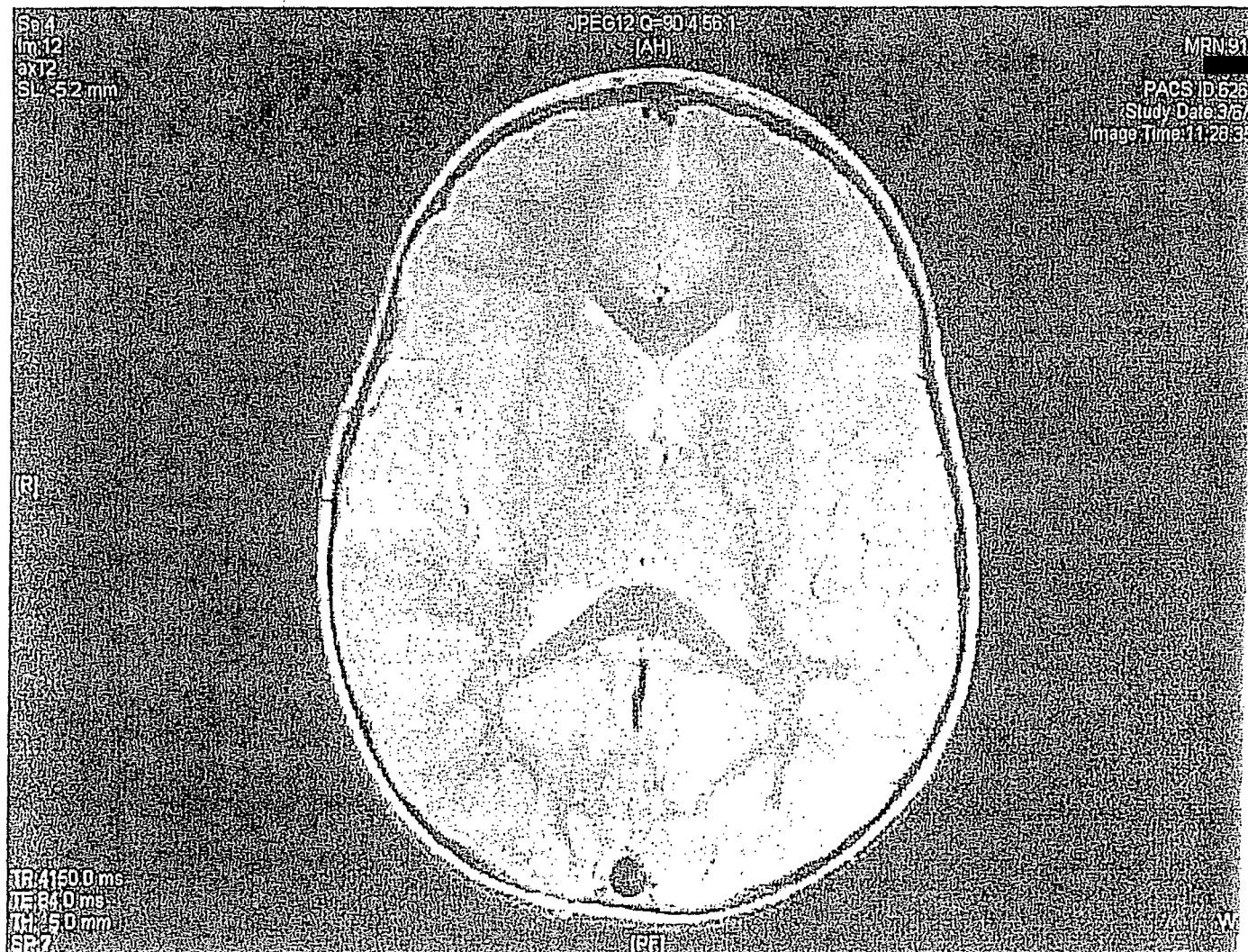
Comments:

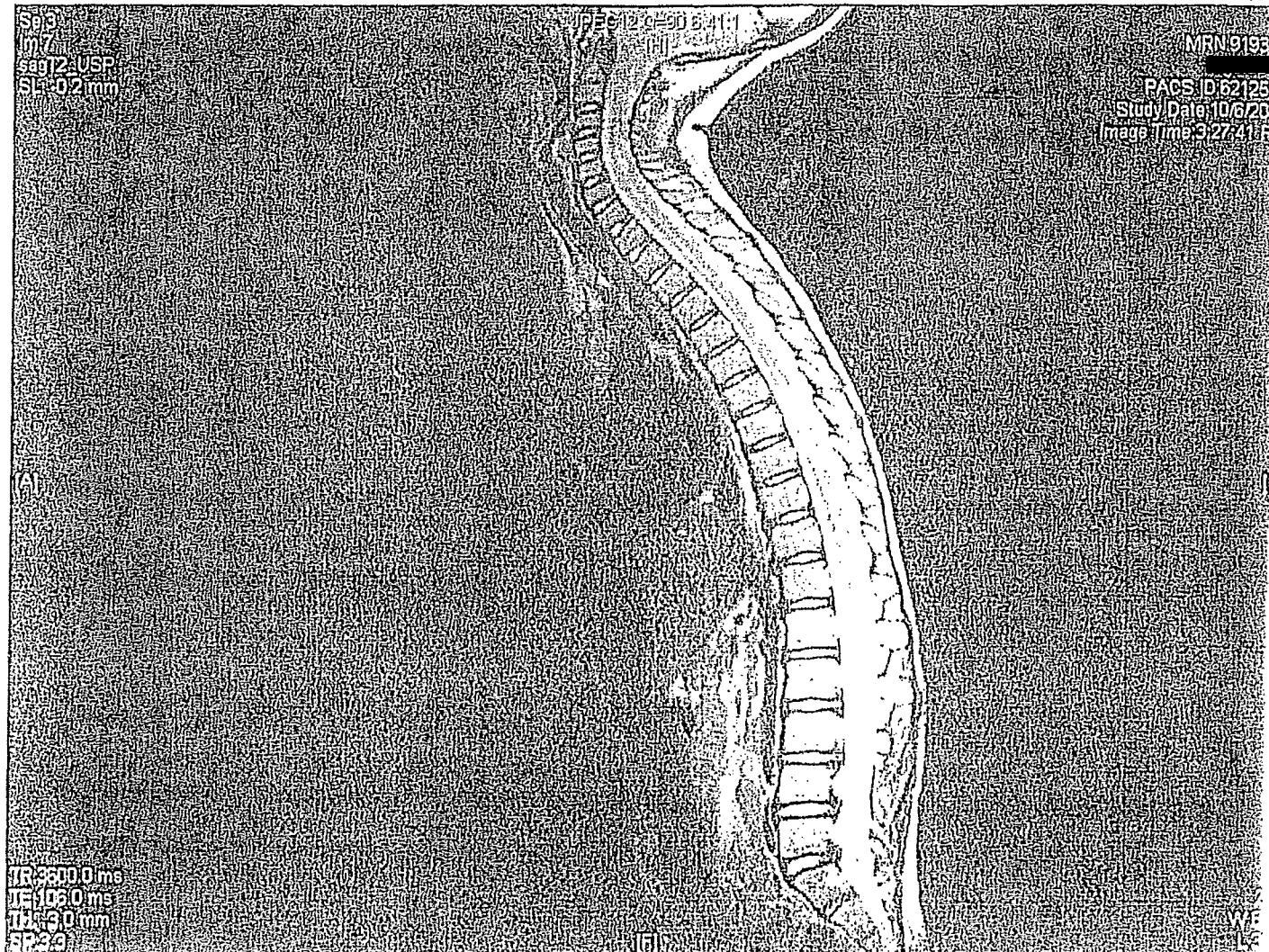
Requested Services: Evaluation, management and physical therapy as needed

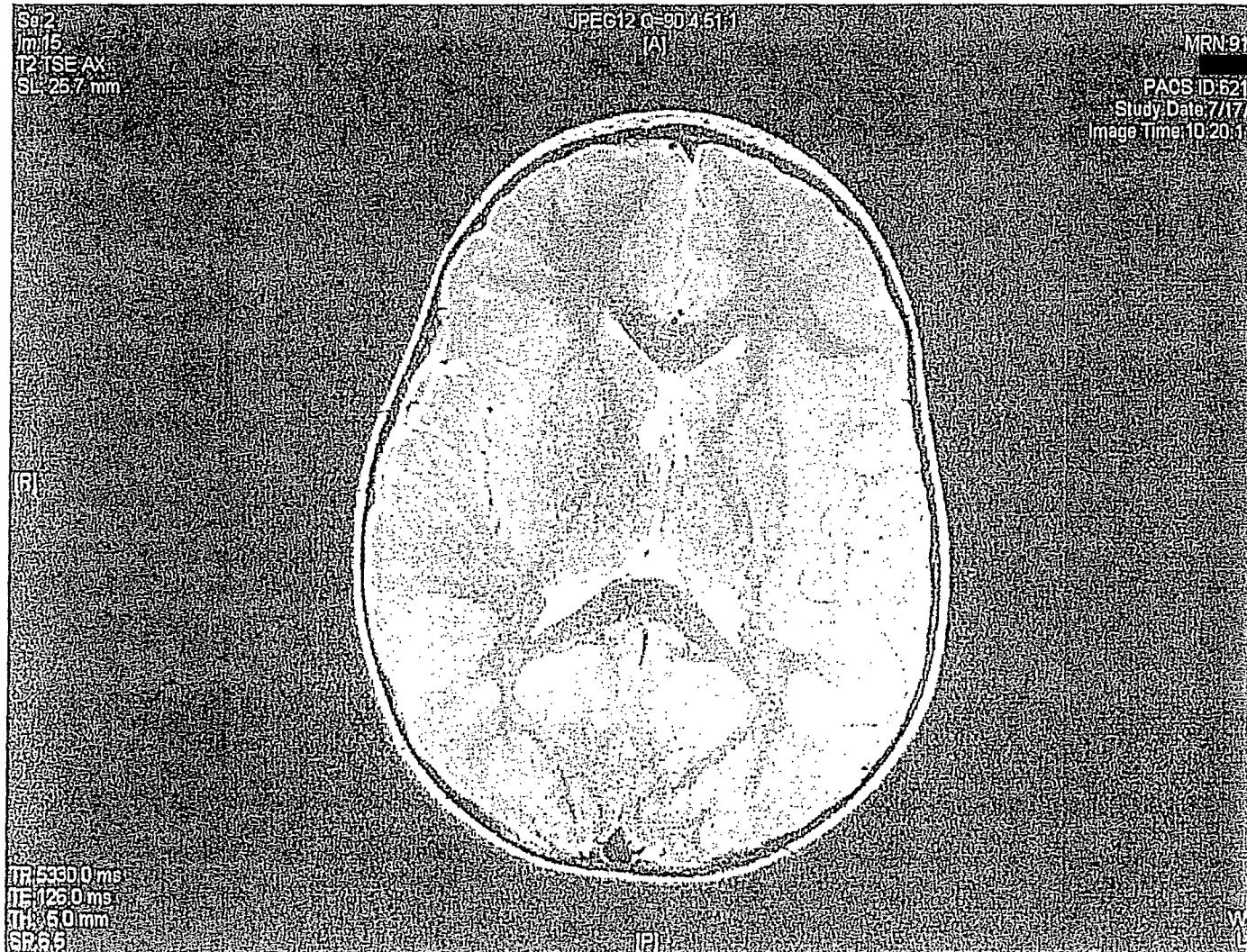
Length of Referral: Effective until March 17, 2010.2

Provider Signature: Date: 03/16/09









MR Total Spine w/o Co.

[REDACTED] - 919383

* Final Report *

Result type: MR Total Spine w/o Cont
Result date: 06 March 2009 11:55
Result status: Auth (Verified)
Result title: MR Spine Total w/o Cont
Performed by: Hurt, Christopher J, MD on 06 March 2009 13:51
Verified by: Pruthi, Sumit , MD on 08 March 2009 11:04
Encounter Info: 90204250, CHMC, Outpatient, 03/06/09 -

*** Final Report ***

Reason For Exam
syrinx

Results

Clinical History: [REDACTED] girl status post Chiari I malformation decompression, now with new urinary incontinence and headache

Examination: MRI brain and complete spine without contrast

Comparison: 1 December 2008

Technique:

MR Brain: Sagittal T1, T2; axial T1, T2, FLAIR, diffusion with ADC; and coronal T2. CSF flow studies also performed.

MR Spine: Sagittal and Axial T1 and T2 of the cervical, thoracic, and lumbar spine.

Findings:

Evaluation is somewhat limited secondary to patient motion degradation.

Brain:

Again, patient is status post midline suboccipital craniectomy for Chiari I malformation. There is persistent crowding of the foramen magnum, with low-lying cerebellar tonsils. Previously visualized posterior pseudomeningocele has resolved. CSF flow studies reveal similar degree of severe posterior CSF flow attenuation. Nonetheless, there is decreased anterior CSF flow, which is now moderately attenuated.

Again, there is some tortuosity to the straight sinus, which appears somewhat ectatic.

The ventricles, sulci and cisterns are normal and unchanged. There is no new parenchymal abnormality. There is no diffusion restriction abnormality to indicate acute infarct. Myelination pattern is normal for age. The corpus callosum is normal. Posterior pituitary bright spot is present. There is no extra-axial fluid collection.

Printed by: Carron, Michele , RN
Printed on: 03/09/09 11:28

Page 1 of 3
(Continued)

MR Total Spine w/o Co. [REDACTED] [REDACTED]

* Final Report *

The mastoids, paranasal sinuses, and orbits are normal.

Spine:

Again, patient is status post resection of the posterior aspect of the C1 ring for Chiari decompression. There is now absence of portions of the posterior elements at L3-L5, related to introduction of lumboperitoneal intrathecal catheter. Susceptibility artifact in the right posterior abdominal wall upper lumbar region is demonstrated. Intrathecal portion of catheter is noted, exerting anterior mass-effect on the cord at T10-T11.

The alignment is normal. The marrow signal is normal. Based on counting from above, there are a normal number of vertebral bodies.

No disc pathology.

The conus ends at L1. No lipoma of the filum terminale. The thecal sac ends at S1-2.

There is increased extent and prominence of punctate linear and beaded dilatation of the central canal indicating worsening syrinx throughout the entire spine. Maximum anteroposterior dimension of the syrinx now measures up to 5 mm (previously 3 mm).

Moderate amount of free fluid is noted within the pelvis, likely from lumboperitoneal shunt.

Impression:

Increased extent and prominence of syrinx throughout the entire spine, as described above.

Apparent decrease in anterior CSF flow at the foramen magnum. While a portion of this change in flow may be related to alterations in head position, which is more extended on the present study compared with the prior, there may be true worsening in CSF flow at the foramen magnum.

Resolution of pseudomeningocele.

Status post lumboperitoneal shunt placement. Extent of mass-effect on the anterior aspect of the cord at T10-T11 apparently related to the intrathecal portion of the catheter may be greater than expected. Please correlate clinically.

Otherwise stable examination compared with 1 December 2008 in patient status post decompression for Chiari I malformation.

Signature Line

Resident: Hurt, Christopher J, MD

I have personally reviewed this study
and agree with the report above.

Printed by: Carron, Michele , RN
Printed on: 03/09/09 11:28

Page 2 of 3
(Continued)

MR Total Spine w/o Cor.

[REDACTED] - 919383

* Final Report *

S,P/CJH

Radiologist: Pruthi, Sumit , MD

Completed Action List:

- * Order by Pearce, Katherine J, ARNP on 10 October 2008 16:15
- * Perform by Bryant, Charles , RT on 06 March 2009 11:55
- * Assist by Pruthi, Sumit , MD on 06 March 2009 11:55
- * VERIFY by Pruthi, Sumit , MD on 08 March 2009 11:04 08 March 2009 11:04

Printed by: Carron, Michele , RN
Printed on: 03/09/09 11:28

Page 3 of 3
(End of Report)

JOSHUA TREE PHYSICAL THERAPY

REGISTRATION FORM

This information is necessary so that we may serve your needs
Any/all information will not be released without your written consent

Today's date: 3/16/09

Referred By:

PATIENT INFORMATION

Patient's last name: [REDACTED]

First: [REDACTED]

 Mr. Miss Mrs. Ms.

Marital status (circle one)

Single / Mar / Div / Sep / Wid

Is this your legal name?

If not, what is your legal name?

(Former name): [REDACTED]

Birth date: [REDACTED]

Age: [REDACTED]

Sex: F

 M Yes No

Street address: 2417 E. St James

Social Security no.: [REDACTED]

Home phone no.: [REDACTED]

(209) 762-5619

P.O. box:

City: Hayden

State: ID

ZIP Code: 83835

Occupation:

Employer:

Employer phone no.: ()

Referring Physician: Dr. Westcott

Referring Physician Phone #: (209) 242-5437

Primary Physician: Same

Primary Physician Phone #: ()

Date of Injury:

Type of Injury: Work Related MVA Other Unknown []

How did your injury/ symptoms occur?

Congenital

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:

April Bryant

Birth date:

7/28/80

Address (if different):

Home phone no.: ()

Is this person a patient here?

 Yes No

Occupation:

Employer: Stay @ Home Mom

Employer address:

Employer phone no.: ()

Is this patient covered by insurance? Yes No

Please indicate primary insurance:

Blue Cross / Medicaid

Coverage date: [REDACTED]

Referral Information : Initial Referral Received

 Yes No

Length of service approved:

Follow up date:

Subscriber's name:

Subscriber's S.S. no.:

Birth date:

Group no.:

Policy no.:

Co-pay:

\$

Patient's relationship to subscriber:

 Self Spouse Child Other

Name of secondary insurance (if applicable):

Subscriber's name:

Group no.:

Policy no.:

Patient's relationship to subscriber:

 Self Spouse Child Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):

Relationship to patient:

Home phone no.: ()

Work phone no.: ()

Authorization for release of information: I authorize Kevin J. Sgroi, RPT, to release all medical information requested by my health insurance carrier, Me or any other third-party payers. I authorize Kevin J. Sgroi, RPT, to release all medical information to my referring physician and my primary (family) physician. I authorize Kevin J. Sgroi, RPT, to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage payments under my policy. I direct the insurance company or health plan administrator to release such information to Kevin J. Sgroi, RPT.

Assignment of Benefits: I request that payment of authorized insurance benefits be made on my behalf to Kevin J. Sgroi, RPT. I agree that these provisions remain in effect until I provide written revocation to Kevin J. Sgroi, RPT. I further agree that should my insurance carrier and /or health plan administer deem my treatment, in full or part is not covered that I am responsible for all charges incurred as a result of treatment rendered by Kevin J. Sgroi, RPT and associates.

Patient/Guardian signature

April Bryant

Date 3/16/09

CONFIDENTIAL INFORMATION

Welcome. We want to make your appointment as pleasant and comfortable as possible. If at any time you have questions regarding your therapy session, please let us know.

NAME [REDACTED] HOME # 762-5619 WORK # [REDACTED]

ADDRESS 2417 E. St. James CITY Hayden STATE Id ZIP 83333

DATE OF BIRTH [REDACTED] AGE [REDACTED] M [REDACTED] F ✓ MARITAL STATUS [REDACTED]

OCCUPATION [REDACTED] REFERRED BY Dr. Westcott

HAVE YOU EVER RECEIVED MASSAGE THERAPY? YES NO

TYPE OF MASSAGE EXPERIENCED: DEEP TISSUE SWEDISH OTHER

ARE YOU TAKING MEDICATION? Yes DESCRIBE HCTZ, Tylenol, oxydodore

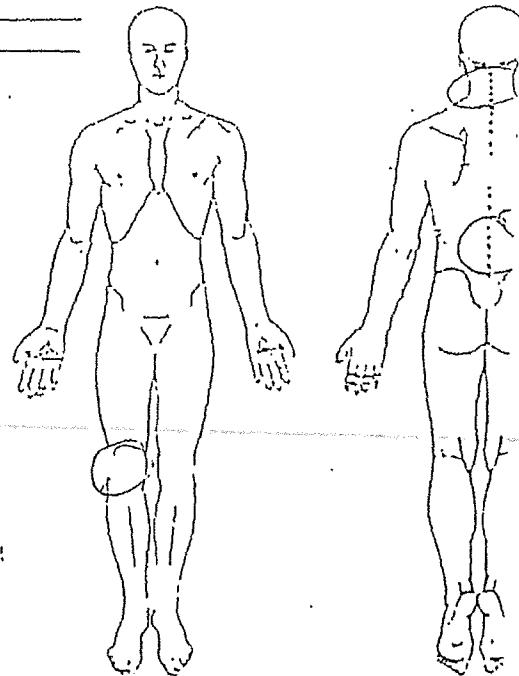
ARE YOU PREGNANT? [REDACTED]

HAVE YOU CONSUMED ALCOHOL IN THE PAST 24 HOURS? YES NO

DO YOU HAVE A HISTORY OF THE FOLLOWING?

<input type="checkbox"/> accident	<input type="checkbox"/> sprains	<input type="checkbox"/> mastectomy
<input checked="" type="checkbox"/> neck pain	<input type="checkbox"/> seizures	<input type="checkbox"/> breast augmentation
<input type="checkbox"/> whiplash	<input type="checkbox"/> abdominal pain	<input type="checkbox"/> diabetes
<input checked="" type="checkbox"/> headaches	<input type="checkbox"/> nervous tension	<input type="checkbox"/> varicose veins
<input type="checkbox"/> shoulder pain	<input type="checkbox"/> arthritis, bursitis or gout	<input type="checkbox"/> high blood pressure
<input type="checkbox"/> upper back pain	<input type="checkbox"/> allergies to oils or perfumes	<input type="checkbox"/> stroke
<input type="checkbox"/> mid back pain	<input type="checkbox"/> wear contacts	<input type="checkbox"/> heart attack
<input checked="" type="checkbox"/> low back pain	<input type="checkbox"/> scoliosis	<input type="checkbox"/> cancer
<input type="checkbox"/> joint aches	<input checked="" type="checkbox"/> surgery	<input type="checkbox"/> colitis
<input type="checkbox"/> decreased range of motion	<input type="checkbox"/> fibromyalgia	<input type="checkbox"/> HIV
<input type="checkbox"/> broken bones	<input type="checkbox"/> carpal tunnel syndrome	<input type="checkbox"/> [REDACTED]
<input type="checkbox"/> scoliosis		

PLEASE INDICATE WITH AN (X), THE
YOU ARE FEELING DISCOMFO



DO YOU HAVE ANY OF THE FOLLOWING TODAY?

<input type="checkbox"/> sunburn	<input type="checkbox"/> open cuts, bruises, burns
<input type="checkbox"/> inflammation	<input type="checkbox"/> irritated skin rash
<input type="checkbox"/> severe pain	<input type="checkbox"/> poison ivy
<input type="checkbox"/> headache	<input type="checkbox"/> cold/flu

WHAT ARE YOUR GOALS/EXPECTATIONS FOR THIS
THERAPY SESSION?

PLEASE READ THE FOLLOWING AND SIGN BELOW:

I understand that this massage is not a replacement for medical care and that no diagnosis will be made.

DATE: 3/16/09 SIGNATURE Dave Bryant

PRIVACY PRACTICES ACKNOWLEDGEMENT

I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES AND I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT.

NAME April Bryant DATE OF BIRTH

SIGNATURE April Bryant DATE

Notification is required for inpatient admissions and prior authorization is required for selected hospitalization and non-hospitalization services. Call as soon as you know that you or your eligible dependents will be admitted. Failure to call may affect your benefit payments. Call (208) 331-7535 or 1-800-743-1871

WellPoint nextRX: 1-877-850-0180
(for location of participating pharmacy)

Customer Services: (208) 331-7347 or 1-800-627-1188

When you are outside the state of Idaho, call the BlueCard Access Number at: 1-800-810-2583 to locate a medical provider. HOSPITAL OR PHYSICIANS: Please file your claims with your local BlueCross BlueShield Plan.

Blue Cross of Idaho • P.O. Box 7408 • Boise, Idaho 83707
www.bcidaho.com

Notification is required for inpatient admissions and prior authorization is required for selected hospitalization and non-hospitalization services. Call as soon as you know that you or your eligible dependents will be admitted. Failure to call may affect your benefit payments. Call (208) 331-7535 or 1-800-743-1878.

WellPoint nextRX: 1-877-850-0180
(for location of participating pharmacy)

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When you are outside the state of Idaho, call the BlueCard Access Number at: 1-800-810-2583 to locate a medical provider. HOSPITAL OR PHYSICIANS: Please file your claims with your local BlueCross BlueShield Plan.

Blue Cross of Idaho • P.O. Box 7408 • Boise, Idaho 83707
www.bcidaho.com



An Independent Licensee of the Blue Cross and Blue Shield Association

Managed Care Faculties Name

WAYNE E. BRYANT
Enrollee ID BC/BS Group #
XMH970191763 110,610 10021090
PCP:Non-PCP
\$30.00 / \$10.00

Preadmission Review required for all (initial) admissions

**Eligibility for
Health and Pharmacy Benefits**

Member Name

Primary Care Physician
WESTCOTT, RONDA L.

Will bring Medicaid card in
by Referral

Medicaid

1643066 Dr. Rhonda Cox
Case # 85957 10/25/2011
Lakeside

Bonnie Pilcher
Suite 201
1120 Ironwood Drive
Coeur D'Alene Id 83814



IDAHO DEPARTMENT OF
HEALTH & WELFARE

We provide interpreter services at no cost. If you need help reading this letter, please call us at 1-866-262-8640. After your call is answered, please wait on the line while you are connected with a translator.

Nosotros proveemos los servicios de un intérprete, sin costo alguno. Si necesita ayuda leyendo esta carta por favor llámenos al 1-866-262-8640. Cuando contesten su llamada, favor de esperar un momento en la línea mientras le conectan con un traductor.

2417 E St James
Hayden ID 83835

March 6, 2009

Case Number 859571

Important Information About
Your Child In-Home Health Care

Your Retroactive Health Coverage is approved:

November 2008 for
December 2008 for
 January 2009 for

If you have been approved for Retroactive Health Coverage only, you will not get an Idaho Health Coverage Card. Please call me to get your Health Coverage Identification numbers.

If you don't agree with this decision about your application or case, please call me. We can review the facts used to make this decision together or you may ask for a hearing. In a hearing you and I tell a neutral person from outside Health and Welfare, called a hearing officer, about your case. This person will decide if the Department action on your case was correct.

You may ask for a hearing in writing or by calling me. If you make a hearing request in writing you may make a copy for your records. You may use a hearing request form from our office or just write on a piece of paper why you want a hearing. Then mail, fax, or bring your request to my office.

If you would like a hearing, you must make your request by April 5, 2009.

Bonnie Pilcher

208-769-1456 (phone) 208-666-6789 (fax)
pilcherb@dhw.idaho.gov

Dmed# 1643066

Routine For: [REDACTED]
 Created By: Kevin

Jun 30, 2009
 shoulder Bob Pritchard

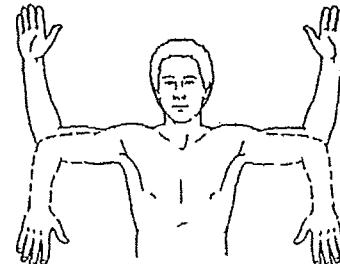
SHOULDER - 86 ROM:
 External / Internal Rotation – in Flexion (Standing)



With upper arms straight out in front and parallel to floor, keep elbows bent at right angles and rotate up then down as far as possible without pain.

Repeat 5 times per set. Do 3 sets per session.
 Do 1 sessions per day.

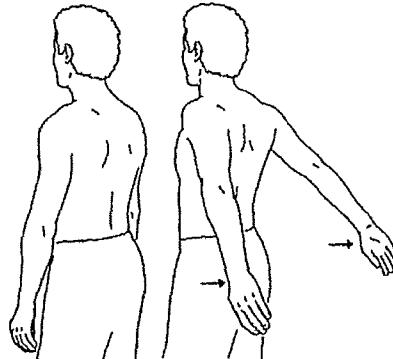
SHOULDER - 85 ROM:
 External / Internal Rotation – in Abduction (Standing)



With upper arms parallel to floor and elbows bent at right angles, gently rotate arms up then down as far as possible without pain.

Repeat 5 times per set. Do 3 sets per session.
 Do 1 sessions per day.

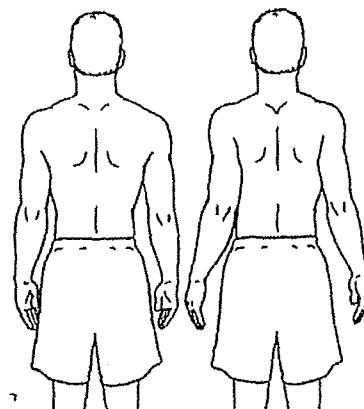
SHOULDER - 87 ROM: Extension (Standing)



Bring arms straight back as far as possible without pain.

Repeat 5 times per set. Do 3 sets per session.
 Do 1 sessions per day.

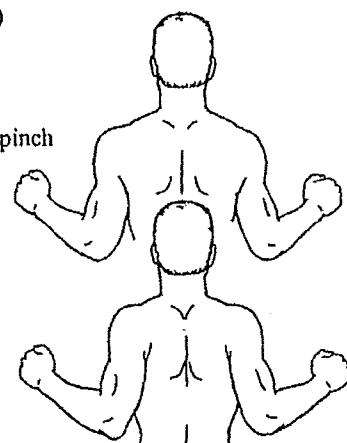
SHOULDER - 101 Scapular Retraction (Standing)



With arms at sides, pinch shoulder blades together.

Repeat 5 times per set.
 Do 3 sets per session.
 Do 1 sessions per day.

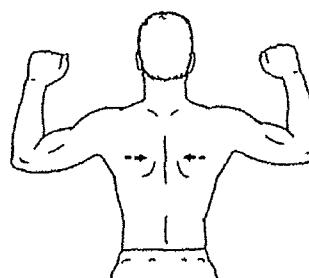
**SHOULDER - 103 Scapular Retraction:
 Elbow Flexion (Standing)**



With elbows bent to 90°, pinch shoulder blades together and rotate arms out, keeping elbows bent.

Repeat 5 times per set.
 Do 3 sets per session.
 Do 1 sessions per day.

**SHOULDER - 104 Scapular Retraction:
 Abduction (Standing)**



With arms elevated and elbows bent to 90°, pinch shoulder blades together and press arms back.

Repeat 5 times per set. Do 3 sets per session.
 Do 1 sessions per day.

CHART COPY

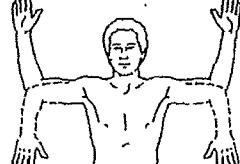
Routine For: XXXXXXXXXX
 Created By: Kevin

Jun 30, 2009
 shoulder Bob Pritchard

SHOULDER - 86 ROM:
 External / Internal Rotation - in Flexion (Standing)

With upper arms straight out in front and parallel to floor, keep elbows bent at right angles and rotate up then down as far as possible without pain.

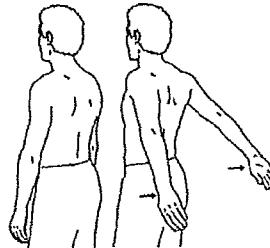
Repeat 5 times per set. Do 3 sets per session.
 Do 1 sessions per day.

SHOULDER - 85 ROM:
 External / Internal Rotation - in Abduction (Standing)

With upper arms parallel to floor and elbows bent at right angles, gently rotate arms up then down as far as possible without pain.

Repeat 5 times per set. Do 3 sets per session.
 Do 1 sessions per day.

SHOULDER - 87 ROM: Extension (Standing)

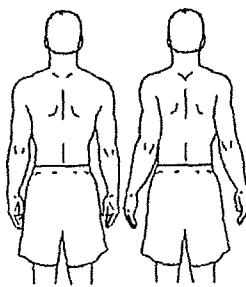


Bring arms straight back as far as possible without pain.

Repeat 5 times per set. Do 3 sets per session.
 Do 1 sessions per day.

SHOULDER - 101 Scapular Retraction (Standing)

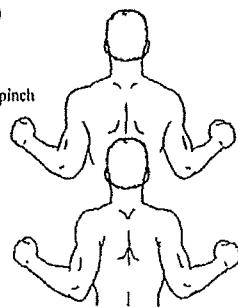
With arms at sides, pinch shoulder blades together.



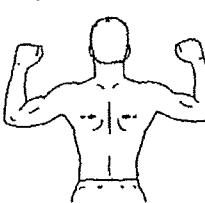
Repeat 5 times per set.
 Do 3 sets per session.
 Do 1 sessions per day.

SHOULDER - 103 Scapular Retraction:
 Elbow Flexion (Standing)

With elbows bent to 90°, pinch shoulder blades together and rotate arms out, keeping elbows bent.



Repeat 5 times per set.
 Do 3 sets per session.
 Do 1 sessions per day.

SHOULDER - 104 Scapular Retraction:
 Abduction (Standing)

With arms elevated and elbows bent to 90°, pinch shoulder blades together and press arms back.

Repeat 5 times per set. Do 3 sets per session.
 Do 1 sessions per day.

NAME: DATE:	SSN: DATE:
SEE TE	
SEE TE	
NEURO Re-Ed	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input checked="" type="checkbox"/> 25 min <input type="checkbox"/> OTHER: To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> OTHER:
Massage	To Musculature of: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Wrist <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER: To Musculature of: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Wrist <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:
Tape/TE	Kinesio tape: x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> Leuko tape: x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> See Flow Sheet 60 min <input type="checkbox"/> Kinesio tape: x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> Leuko tape: x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> See Flow Sheet 60 min <input type="checkbox"/>
Ionto	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Acetic Acid <input type="checkbox"/> x1 treatment <input type="checkbox"/> x 2 treatments <input type="checkbox"/> x 24 minutes <input type="checkbox"/> To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> W/CM2: .50 1.00 1.50 2.00 2.50 To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> W/CM2: .50 1.00 1.50 2.00 2
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Manual	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER: To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> OTHER:
Anodyne	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> OTHER: To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> OTHER:
MH/CP	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> OTHER: To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> OTHER:
Assessment	PT measure for symmetry ③ To Body
Plan	Hold on to KJ Sgroi, PT

Kevin J. Sgroi, RPT

Kevin J. Sgroi, RPT

NAME: <i>J. J. Sgroi</i>	SSN: <i>[Redacted]</i>	
DATE: <i>[Redacted]</i>	DATE: <i>[Redacted]</i>	
Subjective	<i>PT from stated she had no D/H since last Rx</i>	
Objective	<i>No p - muscle Tighthen to para muscle</i>	
NEURO Re-Ed	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input checked="" type="checkbox"/> 25 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> OTHER
Massage	To Musculature of: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Hip <input type="checkbox"/> Low Back <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Wrist <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input checked="" type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> <i>88</i> OTHER:	To Musculature of: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Hip <input type="checkbox"/> Low Back <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Wrist <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:
Tape/TE	Kinesio tape: x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> Leuko tape: x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> See Flow Sheet 60 min <input type="checkbox"/>	Kinesio tape: x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> Leuko tape: x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> See Flow Sheet 60 min <input type="checkbox"/>
Ionto	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Acetic Acid <input type="checkbox"/> x1 treatment <input type="checkbox"/> x 2 treatments <input type="checkbox"/> x 24 minutes <input type="checkbox"/>	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Acetic Acid <input type="checkbox"/> x1 treatment <input type="checkbox"/> x 2 treatments <input type="checkbox"/> x 24 minutes <input type="checkbox"/>
US	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> W/CM2: .50 <input type="checkbox"/> 1.00 <input type="checkbox"/> 1.50 <input type="checkbox"/> 2.00 <input type="checkbox"/> 2.50	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> W/CM2: .50 <input type="checkbox"/> 1.00 <input type="checkbox"/> 1.50 <input type="checkbox"/> 2.00 <input type="checkbox"/> 2.50
Manual	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> A TIME: 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:
Anodyne	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 30 min <input checked="" type="checkbox"/> 45 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> A TIME: 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> OTHER:
M/H/CP	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> OTHER:
Assessment	<i>PT talk well had no c/o t al pain since last Rx</i>	
Plan	<i>Cont to current rx</i> <i>S. J. Sgroi, RPT</i>	

Kevin J. Sgroi, RPT

Kevin J. Sgroi, RPT

Subjective	Pt Dad stated [REDACTED] has not had a HT since last R	Pt Mom stated has had 4 in the past few days.
Objective	Pt not as fatigued today	Pt had minor to no muscle tension & pain Spasms
NEURO Re-Eval	To: C/S <input type="checkbox"/> Shoulders <input checked="" type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input checked="" type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> OTHER:
Massage	To Musculature of: C/S <input type="checkbox"/> Shoulders <input checked="" type="checkbox"/> Mid Back <input type="checkbox"/> Hip <input type="checkbox"/> Low Back <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Wrist <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:	To Musculature of: C/S <input type="checkbox"/> Shoulders <input checked="" type="checkbox"/> Mid Back <input type="checkbox"/> Hip <input type="checkbox"/> Low Back <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Wrist <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:
Tape/TE	Kinesio tape: x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> Leuko tape: x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> See Flow Sheet 60 min <input type="checkbox"/>	Kinesio tape: x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> Leuko tape: x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> See Flow Sheet 60 min <input type="checkbox"/>
Ionto	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Acetic Acid <input type="checkbox"/> x1 treatment <input type="checkbox"/> x 2 treatments <input type="checkbox"/> x 24 minutes <input type="checkbox"/>	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Ankle <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Acetic Acid <input type="checkbox"/> x1 treatment <input type="checkbox"/> x 2 treatments <input type="checkbox"/> x 24 minutes <input type="checkbox"/>
US	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> W/CM2: .50 1.00 1.50 2.00 2.50	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> W/CM2: .50 1.00 1.50 2.00 2.50
Manual	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:
Analyne	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> OTHER:
M/H/CP	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> OTHER:
Assessment	Pt tol R well had no C10 pain PT	Pt tol R well had no C10 pain PT
Plan	Cont to current pos D. Moyer, PT	Cont to current pos D. Moyer, PT

NAME: <u>1/14/09</u>	SSN: <u>6/2/09</u>
Subjective	<p>PT mom stated [REDACTED] was playing for a 1/16 then 1/10 score 44-44</p> <p>PT dad stated he 1/4 have had since not having PT</p>
Objective	<p>No significant muscle tension to back</p> <p>PT very fatigued today</p>
NEURO Re-Ed	<p>To: C/S <input type="checkbox"/> Shoulders <input checked="" type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input checked="" type="checkbox"/> 25 min <input type="checkbox"/> OTHER:</p> <p>To: C/S <input type="checkbox"/> Shoulders <input checked="" type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> OTHER:</p>
Massage	<p>To Musculature of: C/S <input type="checkbox"/> Shoulders <input checked="" type="checkbox"/> Mid Back <input type="checkbox"/> Hip <input type="checkbox"/> Low Back <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Wrist <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:</p> <p>To Musculature of: C/S <input type="checkbox"/> Shoulders <input checked="" type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Wrist <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER: ITB + PERIFORMIS</p>
Tape/TE	<p>Kinesio tape: x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> Leuko tape: x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> See Flow Sheet 60 min <input type="checkbox"/></p> <p>Kinesio tape: x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> Leuko tape: x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> See Flow Sheet 60 min <input type="checkbox"/></p>
Ionto	<p>To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Acetic Acid <input type="checkbox"/> x1 treatment <input type="checkbox"/> x 2 treatments <input type="checkbox"/> x 24 minutes <input type="checkbox"/></p> <p>To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> W/CM2: .5 <input type="checkbox"/> 1.0 <input type="checkbox"/> 1.5 <input type="checkbox"/> 2.0 <input type="checkbox"/> 2.5 <input type="checkbox"/></p>
US	<p>To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> W/CM2: .5 <input type="checkbox"/> 1.0 <input type="checkbox"/> 1.5 <input type="checkbox"/> 2.0 <input type="checkbox"/> 2.5 <input type="checkbox"/></p> <p>To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> W/CM2: .5 <input type="checkbox"/> 1.0 <input type="checkbox"/> 1.5 <input type="checkbox"/> 2.0 <input type="checkbox"/> 2.5 <input type="checkbox"/></p>
Manual	<p>To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:</p> <p>To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:</p>
Anodyne	<p>To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> OTHER:</p> <p>To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> OTHER:</p>
MH/CP	<p>To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> OTHER:</p> <p>To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> OTHER:</p>
Assessment	<p>PT well had no cr/o HAPR</p> <p>PT well had no cr/o HAPR</p>
Plan	<p>None to current pt</p> <p>None to current pt</p> <p>Kevin J. Sgroi, RPT</p> <p>Kevin J. Sgroi, RPT</p>

NAME: DATE:	SSN: DATE:	
Subjective	<i>PT stated she was Tired Today</i>	<i>PT mother stated has not had any HA since last</i>
Objective	<i>PT to have photo taken today</i>	<i>No + muscle tension to back</i>
NEURO Re-Ed	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> K Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> OTHER
Massage	To Musculature of: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Hip <input type="checkbox"/> Low Back <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Wrist <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:	To Musculature of: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Hip <input type="checkbox"/> Low Back <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> H Wrist <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER: <i>Glutes, ITB, Piriformis</i>
Tape/TE	Kinesio tape: x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> Leuko tape: x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> See Flow Sheet 60 min <input type="checkbox"/>	Kinesio tape: x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> Leuko tape: x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> See Flow Sheet 60 min <input type="checkbox"/>
Ionto	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Acetic Acid <input type="checkbox"/> x1 treatment <input type="checkbox"/> x 2 treatments <input type="checkbox"/> x 24 minutes <input type="checkbox"/>	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Ankle <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Acetic Acid <input type="checkbox"/> x1 treatment <input type="checkbox"/> x 2 treatments <input type="checkbox"/> x 24 minutes <input type="checkbox"/>
US	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> W/CM2: .50 <input type="checkbox"/> 1.00 <input type="checkbox"/> 1.50 <input type="checkbox"/> 2.00 <input type="checkbox"/> 2.50 <input type="checkbox"/>	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> K Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> W/CM2: .50 <input type="checkbox"/> 1.00 <input type="checkbox"/> 1.50 <input type="checkbox"/> 2.00 <input type="checkbox"/> 2.50 <input type="checkbox"/>
Manual	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> TIME: 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:
Amodyne	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> TIME: 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> OTHER:
MH/CP	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> OTHER: <i>Laser x 5 min</i>
Assessment	<i>PT tol R well a little Tired PT</i>	<i>PT tol R well a no 0/10 pain D/R</i>
Plan	<i>cont to current doc</i> <i>J. Sgroi, RPT</i>	<i>cont to current doc</i> <i>J. Sgroi, RPT</i>

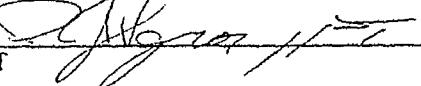
Kevin J. Sgroi, RPT

Kevin J. Sgroi, RPT

NAME: [REDACTED]	SS: [REDACTED]	
DATE: 5/5/09	DATE: 5/5/09	
Subjective	PT. now stated her Shunt is draining to much est	
Objective	No p - muscle tension low back muscle tension	
NEURO Re-Ed	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input checked="" type="checkbox"/> 25 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input checked="" type="checkbox"/> 20 min <input type="checkbox"/> OTHER:
Massage	To Musculature of: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Hip <input type="checkbox"/> Low Back <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Wrist <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER: ITB & Pectenitis	To Musculature of: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Wrist <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input checked="" type="checkbox"/> OTHER: ITB & Glutes
Tape/TE	Kinesio tape: x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> Leuko tape: x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> See Flow Sheet 60 min <input type="checkbox"/>	Kinesio tape: x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> Leuko tape: x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> 60 min <input type="checkbox"/>
Ionto	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Dexanethasone <input type="checkbox"/> Acetic Acid <input type="checkbox"/> x1 treatment <input type="checkbox"/> x 2 treatments <input type="checkbox"/> x 24 minutes <input type="checkbox"/>	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Ankle <input type="checkbox"/> Dexanethasone <input type="checkbox"/> Acetic Acid <input type="checkbox"/> x1 treatment <input type="checkbox"/> x 2 treatments <input type="checkbox"/> x 24 minutes <input type="checkbox"/>
US	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> W/CM2: .50 1.00 1.50 2.00 2.50	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> W/CM2: .50 1.00 1.50 2.00 2.50
Manual	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:
Anodyne	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> OTHER:
MU/CP	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> OTHER:
Assessment	PT talk well had no crp seen P/R	PT talk well had no crp seen P/R
Plan	Cont c current rx J. Sgroi, PT	Cont c current rx J. Sgroi, PT

Kevin J. Sgroi, RPT

Kevin J. Sgroi, RPT

NAME:	SSN:
DATE: 1/23/09	DATE: 4/28/09 ✓
Subjective	PC Monstated has been sick these few wks
Objective	NO signif + - muscle tension to back
NEURO Re-Ed	To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UEO□ L UEO□ R LEO□ L LEO□ Hand□ Elbow□ Wrist□ Knee□ Ankle□ TIME: 10 min □ 15 min □ 20 min □ 25 min □ OTHER:
Massage	To Musculature of: C/S□ Shoulders□ Mid Back□ Hip□ Low Back□ R UEO□ L UEO□ R LEO□ L LEO□ Hand□ Wrist□ Elbow□ Knee□ Ankle□ TIME: 20 min □ 25 min □ 30 min □ OTHER: Glutes, ITB, Piriformis
Tape/TE	Kinesio tape: x 1 □ x 2 □ x 3 □ Leuko tape: x 1 □ x 2 □ x 3 □ THERAPEUTIC EXERCISES: 15 min □ 30 min □ 45 min □ See Flow Sheet 60 min □
Ionto	To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UEO□ L UEO□ R LEO□ L LEO□ Hand□ Elbow□ Wrist□ Knee□ Ankle□ Dexamethasone □ Acetic Acid □ x1 treatment □ x 2 treatments □ x 24 minutes □
US	To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UEO□ L UEO□ R LEO□ L LEO□ Hand□ Elbow□ Wrist□ Knee□ Ankle□ TIME: 10 min □ 15 min □ 20 min □ 25 min □ W/CM2: .5□ 1.0□ 1.5□ 2.0□ 2.5□
Manual	To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UEO□ L UEO□ R LEO□ L LEO□ Hand□ Elbow□ Wrist□ Knee□ Ankle□ TIME: 15 min □ 20 min □ 25 min □ 30 min □ OTHER:
Anodyne	To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UEO□ L UEO□ R LEO□ L LEO□ Hand□ Elbow□ Wrist□ Knee□ Ankle□ TIME: 30 min □ 45 min □ OTHER:
MIVCP	To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UEO□ L UEO□ R LEO□ L LEO□ Hand□ Elbow□ Wrist□ Knee□ Ankle□ TIME: 20 min □ OTHER:
Notes	PC stated Russell had no cr/o pain PT
Plan	Cont to currng PT 

Kevin J. Sgroi, RPT

Kevin J. Sgroi, RPT

		NAME: 3/24/09	SSN: [REDACTED]
		DATE: 3/24/09	DATE: 3/26/09
Subjective	<p>PT mother stated [REDACTED] did not have HT for 4-5 days</p>		
Objective	<p>No r/t muscle Tension C/S / B - Rld</p>		
NEURO Re-Ed	<p>To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input checked="" type="checkbox"/> 25 min <input type="checkbox"/> OTHER:</p>		
Massage	<p>To Musculature of: C/S <input type="checkbox"/> Shoulders <input checked="" type="checkbox"/> Mid Back <input checked="" type="checkbox"/> Hip <input checked="" type="checkbox"/> Low Back <input checked="" type="checkbox"/> R UEO <input checked="" type="checkbox"/> L UEO <input checked="" type="checkbox"/> R LEO <input checked="" type="checkbox"/> L LEO <input checked="" type="checkbox"/> Hand <input checked="" type="checkbox"/> Wrist <input checked="" type="checkbox"/> Elbow <input checked="" type="checkbox"/> Knee <input checked="" type="checkbox"/> Ankle <input checked="" type="checkbox"/> TIME: 20 min <input checked="" type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:</p>		
Tape/TE	<p>Kinesio tape: x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> Leuko tape: x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> See Flow Sheet 60 min <input type="checkbox"/></p>		
Ionto	<p>To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Acetic Acid <input type="checkbox"/> x1 treatment <input type="checkbox"/> x 2 treatments <input type="checkbox"/> x 24 minutes <input type="checkbox"/></p>		
US	<p>To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> W/CM2: .50 1.00 1.50 2.00 2.50</p>		
Manual	<p>To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:</p>		
Anodyne	<p>To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 30 min <input checked="" type="checkbox"/> 45 min <input type="checkbox"/> OTHER:</p>		
MIVCP	<p>To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> OTHER:</p>		
Assessment	<p>PT Tel well had no C/O HT/ pain to L</p>		
Plan	<p>Can't correct doc D. Sgroi, RPT</p>		

Kevin J. Sgroi, RPT

Kevin J. Sgroi, RPT

NAME:	DATE:	SSN:
DATE:	3/16/09	DATE: 3/19/09
Subjective	SEE IE	RE Pt now stated had a H/H for = 2 days P last 2s. No pain c/ H/H today
Objective	SEE IE	NO signif. S- muscle tension
NEURO Re-Ed	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input checked="" type="checkbox"/> 25 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> OTHER:
Massage	To Musculature of: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Hip <input type="checkbox"/> Low Back <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Wrist <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input checked="" type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:	To Musculature of: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Wrist <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> HIPS TIME: 20 min <input checked="" type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:
Tape/TE	Kinesio tape: x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> Leuko tape: x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> See Flow Sheet 60 min <input type="checkbox"/>	Kinesio tape: x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> Leuko tape: x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> 60 min <input type="checkbox"/> See Flow Sheet 60 min <input type="checkbox"/>
Ionto	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Acetic Acid <input type="checkbox"/> x1 treatment <input type="checkbox"/> x 2 treatments <input type="checkbox"/> x 24 minutes <input type="checkbox"/>	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Ankle <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Acetic Acid <input type="checkbox"/> x1 treatment <input type="checkbox"/> x 2 treatments <input type="checkbox"/> x 24 minutes <input type="checkbox"/>
US	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> W/CM2: .5 <input type="checkbox"/> 1.0 <input type="checkbox"/> 1.5 <input type="checkbox"/> 2.0 <input type="checkbox"/> 2.5 <input type="checkbox"/>	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> W/CM2: .5 <input type="checkbox"/> 1.0 <input type="checkbox"/> 1.5 <input type="checkbox"/> 2.0 <input type="checkbox"/> 2 <input type="checkbox"/>
Manual	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> K TIME: 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:
Anodyne	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 30 min <input checked="" type="checkbox"/> 45 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> K TIME: 30 min <input checked="" type="checkbox"/> 45 min <input type="checkbox"/> OTHER:
M/R/CP	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elb <input type="checkbox"/> K <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> OTHER:
Assessment	RE at 1/2 we elicited no c/o H/H to R	RE at 1/2 we elicited had no c/o pain P/R
Plan	Cont'd current pt D/Sg 90/70	Cont'd current pt D/Sg 90/70

Kevin J. Sgroi, RPT

Kevin J. Sgroi, RPT



STYLE OF
CASE :

VS.

MILHORAT, M.D., et al.

PERTAIN TO :

FROM : Joshua Tree Physical Therapy (incl. Kevin Sigroi, M.D.) (Medical
Records Update)

DELIVER TO :

Christina Ctorides
Goldsmith Ctorides & Rodriguez, LLP.
140 Sylvan Avenue, 3rd Floor
Englewood Cliffs, NJ 07632

CASE NO.:

COURT:

Order No. 102305.020

No.

[REDACTED]

§
§
§
§
§
§
§
§

vs.

MILHORAT, M.D., et al.

AFFIDAVIT

Records Pertaining To: [REDACTED]

Type of Records:

ANY AND ALL MEDICAL RECORDS FROM 01/01/2010 TO THE PRESENT, including but not limited to patient information sheets, patient questionnaires, medical history forms, consents for treatment, and any other type of "new patient" documentation; doctor's notes; nurse's notes; patient evaluation forms; narratives; insurance records; photographs; reports; office notes; prescription records and/or documentation related to medication administration; test results; physical therapy, occupational therapy and/or speech therapy records; correspondence; files and/or charts; telephone message slips; copies of any type of notation(s) on any file folder

Before me, the undersigned authority, personally appeared Bonnie Burrage,
who, being by me duly sworn, deposed as follows: (Custodian of Records)

My name is Bonnie Burrage, I am over eighteen (18) years of age, of sound mind, capable of making this affidavit, and personally acquainted with the facts herein stated:

I am the Custodian of Records for:

Joshua Tree Physical Therapy (incl. Kevin Sigroi, M.D.)

Attached hereto are 21 pages of records from this facility. These records are kept in the regular course of business, and it was the regular course of business for an employee or representative of this facility, with knowledge of the act, event, condition, opinion, or diagnosis, recorded to make the record or to transmit information thereof to be included in such record; and the record was made at or near the time or reasonably soon thereafter. The records attached hereto are the original or exact duplicates of the original.

Bonnie Burrage
AFFIANT (Custodian of Records)

Sworn to and subscribed before me on the 9th day of May, 2014.

John J. Simon
NOTARY PUBLIC
My Commission Expires: May 16, 2014

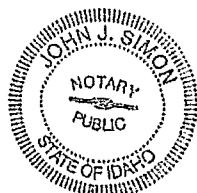


Table of Contents

	Image Page No.
001-MEDICAL-RECORDS.....	1

Name: 4/26/11 ✓		Date: 4/28/11 ✓
SUBJECTIVE	Pt had no c/o pain since last visit	Pt c/o Tingly in ft today
OBJECTIVE	Pt non restricted c/o & Tingly in hands	No c/o Tingly in hands
NEURO R/E-D	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIPS □ R UED L UED R LED L LED HANDS □ WRIST □ ELBOWS □ KNEES □ ANKLES □ FEET □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ 30 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIPS □ R UED L UED R LED L LED HANDS □ WRIST □ ELBOWS □ KNEES □ ANKLES □ FEET □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ 30 MIN □ OTHER:
MASSAGE	TO MUSCULATURE OF: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIPS □ R UED L UED R LED L LED HANDS □ WRIST □ ELBOWS □ KNEES □ ANKLES □ FEET □ TIME: 20 MIN □ 25 MIN □ 30 MIN □ 40 MIN □ OTHER: FA	TO MUSCULATURE OF: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIPS □ R UED L UED R LED L LED HANDS □ WRIST □ ELBOWS □ KNEES □ ANKLES □ FEET □ TIME: 20 MIN □ 25 MIN □ 30 MIN □ 40 MIN □ OTHER: FA
TAPE/TE	KINESIO TAPE: ×10 ×20 ×30 LEUKO TAPE: ×10 ×20 ×30 THERAPEUTIC EXERCISES: 15 MIN □ 30 MIN □ 45 MIN □ 60 MIN □ SEE FLOW SHEET	KINESIO TAPE: ×10 ×20 ×30 LEUKO TAPE: ×10 ×20 ×30 THERAPEUTIC EXERCISES: 15 MIN □ 30 MIN □ 45 MIN □ 60 MIN □ SEE FLOW SHEET
IONTO	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIPS □ R UED L UED R LED L LED HANDS □ WRIST □ ELBOWS □ KNEES □ ANKLES □ FEET □ DEXAMETHASONE □ ACETIC ACID □ ×1 TREATMENT □ ×2 TREATMENTS □ ×24 MINUTES □	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIPS □ R UED L UED R LED L LED HANDS □ WRIST □ ELBOWS □ KNEES □ ANKLES □ FEET □ DEXAMETHASONE □ ACETIC ACID □ ×1 TREATMENT □ ×2 TREATMENTS □ ×24 MINUTES □
US	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIPS □ R UED L UED R LED L LED HANDS □ WRIST □ ELBOWS □ KNEES □ ANKLES □ FEET □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ W/CM2: .5 □ 1.0 □ 1.5 □ 2.0 □ 2.5 □	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIPS □ R UED L UED R LED L LED HANDS □ WRIST □ ELBOWS □ KNEES □ ANKLES □ FEET □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ W/CM2: .5 □ 1.0 □ 1.5 □ 2.0 □ 2.5 □
MANUAL	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIPS □ R UED L UED R LED L LED HANDS □ WRIST □ ELBOWS □ KNEES □ ANKLES □ FEET □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIPS □ R UED L UED R LED L LED HANDS □ WRIST □ ELBOWS □ KNEES □ ANKLES □ FEET □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ OTHER:
ANODYNE	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIPS □ R UED L UED R LED L LED HANDS □ WRIST □ ELBOWS □ KNEES □ ANKLES □ FEET □ TIME: 30 MIN □ 45 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIPS □ R UED L UED R LED L LED HANDS □ WRIST □ ELBOWS □ KNEES □ ANKLES □ FEET □ TIME: 30 MIN □ 45 MIN □ OTHER:
MHCP	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIPS □ R UED L UED R LED L LED HANDS □ WRIST □ ELBOWS □ KNEES □ ANKLES □ FEET □ TIME: 20 MIN □ 25 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIPS □ R UED L UED R LED L LED HANDS □ WRIST □ ELBOWS □ KNEES □ ANKLES □ FEET □ TIME: 20 MIN □ 25 MIN □ OTHER:
OTHER	IFC ×20 MINUTES □ LASER □ THERAPEUTIC ACTIVITY □ OTHER □	IFC ×20 MINUTES □ LASER □ THERAPEUTIC ACTIVITY □ OTHER □
ASSESSMENT	Pt still R well had no c/o pain JK	Pt talk well had no c/o Tingly ft
PLAN	Cont & current doc JK	Cont & current doc JK

Name: 3/17/11

Date:

e: 4/21/11 ✓

SUBJECTIVE	PT stated the back is feeling better	PT c/o back pain = 4/5/10
OBJECTIVE	No signs/symptoms	PT has been in N.Y. part two w/
NEURO RE-ED	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UED □ L UED □ R LEG □ L LEG □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ 30 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UED □ L UED □ R LEG □ L LEG □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ 30 MIN □ OTHER:
MASSAGE	TO MUSCULATURE OF: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UED □ L UED □ R LEG □ L LEG □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ 30 MIN □ 40 MIN □ OTHER: FA	TO MUSCULATURE OF: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UED □ L UED □ R LEG □ L LEG □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ 30 MIN □ 40 MIN □ OTHER: FA
TAPE/TE	KINESIO TAPE: ×1 □ ×2 □ ×3 □ LEUKO TAPE: ×1 □ ×2 □ ×3 □ THERAPEUTIC EXERCISES: 15 MIN □ 30 MIN □ 45 MIN □ 60 MIN □ SEE FLOW SHEET	KINESIO TAPE: ×1 □ ×2 □ ×3 □ LEUKO TAPE: ×1 □ ×2 □ ×3 □ THERAPEUTIC EXERCISES: 15 MIN □ 30 MIN □ 45 MIN □ 60 MIN □ SEE FLOW SHEET
IONTO	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UED □ L UED □ R LEG □ L LEG □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ DEXAMETHASONE □ ACETIC ACID □ ×1 TREATMENT □ ×2 TREATMENTS □ ×24 MINUTES □	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UED □ L UED □ R LEG □ L LEG □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ DEXAMETHASONE □ ACETIC ACID □ ×1 TREATMENT □ ×2 TREATMENTS □ ×24 MINUTES □
US	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UED □ L UED □ R LEG □ L LEG □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ W/CM2: .5 □ 1.0 □ 1.5 □ 2.0 □ 2.5 □	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UED □ L UED □ R LEG □ L LEG □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ W/CM2: .5 □ 1.0 □ 1.5 □ 2.0 □ 2.5 □
MANUAL	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UED □ L UED □ R LEG □ L LEG □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UED □ L UED □ R LEG □ L LEG □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ OTHER:
ANODYNE	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UED □ L UED □ R LEG □ L LEG □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 30 MIN □ 45 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UED □ L UED □ R LEG □ L LEG □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 30 MIN □ 45 MIN □ OTHER:
MH/CP	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UED □ L UED □ R LEG □ L LEG □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UED □ L UED □ R LEG □ L LEG □ HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ OTHER:
OTHER	IFC×20 MINUTES □ LASER □ THERAPEUTIC ACTIVITY □ OTHER □	IFC×20 MINUTES □ LASER □ THERAPEUTIC ACTIVITY □ OTHER □
ASSESSMENT	PT talk well c/o pain to = to PT if	PT talk well c/o pain to = to PT
PLAN	Cont & current PT D. Sgro, RPT	Cont & current PT R. Sgro, RPT

Kevin J. Sgroi, RPT

Kevin J. Sgroi, RPT

modality sheet

Name: 2/17/11

Date:

Date: 3/3/11

SUBJECTIVE	Re stated she has had Tingling in her hands	Re cont to have Tingling in feet
OBJECTIVE	No S ^o - just tingling	Minor tr in muscle tension low back
NEURO RE-ED	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UED L UED R LED L LED HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UED L UED R LED L LED HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ OTHER:
MASSAGE	TO MUSCULATURE OF: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UED L UED R LED L LED HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ 30 MIN □ 40 MIN □ OTHER:	TO MUSCULATURE OF: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UED L UED R LED L LED HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ 30 MIN □ 40 MIN □ OTHER:
TAPE/TE	KINESIO TAPE: ×1 □ ×2 □ ×3 □ LEUKO TAPE: ×1 □ ×2 □ ×3 □ THERAPEUTIC EXERCISES: 15 MIN □ 30 MIN □ 45 MIN □ 60 MIN □ SEE FLOW SHEET	KINESIO TAPE: ×1 □ ×2 □ ×3 □ LEUKO TAPE: ×1 □ ×2 □ ×3 □ THERAPEUTIC EXERCISES: 15 MIN □ 30 MIN □ 45 MIN □ 60 MIN □ SEE FLOW SHEET
IONTO	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UED L UED R LED L LED HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ DEXAMETHASONE □ ACETIC ACIDE ×1 TREATMENT □ ×2 TREATMENTS □ ×24 MINUTES □	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UED L UED R LED L LED HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ DEXAMETHASONE □ ACETIC ACIDE ×1 TREATMENT □ ×2 TREATMENTS □ ×24 MINUTES □
US	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UED L UED R LED L LED HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ W/CM2: .50 1.00 1.50 2.00 2.50	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UED L UED R LED L LED HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ W/CM2: .50 1.00 1.50 2.00 2.50
MANUAL	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UED L UED R LED L LED HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UED L UED R LED L LED HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 10 MIN □ 15 MIN □ 20 MIN □ 25 MIN □ OTHER:
ANODYNE	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UED L UED R LED L LED HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 30 MIN □ 45 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UED L UED R LED L LED HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 30 MIN □ 45 MIN □ OTHER:
MH/CP	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UED L UED R LED L LED HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ OTHER:	TO: C/S □ SHOULDERS □ MID BACK □ LOW BACK □ HIP □ R UED L UED R LED L LED HAND □ WRIST □ ELBOW □ KNEE □ ANKLE □ FOOT □ TIME: 20 MIN □ 25 MIN □ OTHER:
OTHER	IFC×20 MINUTES □ LASER □ THERAPEUTIC ACTIVITY □ OTHER:	IFC×20 MINUTES □ LASER □ THERAPEUTIC ACTIVITY □ OTHER:
ASSESSMENT	Re felt the well had no c/o Tingling P.R.	Re felt the well had no c/o Tingling P.R.
PLAN	Cont c/avryat P.R. RJ 3/3/11	Cont c/avryat P.R. RJ 3/3/11

Kevin J. Sgroi, RPT

Kevin J. Sgroi, RPT

modality sheet

Name: 2/10/11

Date: 2/10/11

SUBJECTIVE	Pt had no c/o pain since last rx	Pt had no c/o pain since last rx
OBJECTIVE	No significant gait sequence	No T= muscle Tension Low Back
NEURO RE-ED	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LED <input type="checkbox"/> L LED <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> 30 MIN <input type="checkbox"/> OTHER:	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LED <input type="checkbox"/> L LED <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> 30 MIN <input type="checkbox"/> OTHER:
MASSAGE	TO MUSCULATURE OF: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LED <input type="checkbox"/> L LED <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> 30 MIN <input type="checkbox"/> 40 MIN <input type="checkbox"/> OTHER:	TO MUSCULATURE OF: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LED <input type="checkbox"/> L LED <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> 30 MIN <input type="checkbox"/> 40 MIN <input type="checkbox"/> OTHER:
TAPE/TE	KINESIO TAPE: <input type="checkbox"/> x10 <input type="checkbox"/> x20 <input type="checkbox"/> x30 LEUKO TAPE: <input type="checkbox"/> x10 <input type="checkbox"/> x20 <input type="checkbox"/> x30 THERAPEUTIC EXERCISES: 15 MIN <input type="checkbox"/> 30 MIN <input type="checkbox"/> 45 MIN <input type="checkbox"/> 60 MIN <input type="checkbox"/> SEE FLOW SHEET	KINESIO TAPE: <input type="checkbox"/> x10 <input type="checkbox"/> x20 <input type="checkbox"/> x30 LEUKO TAPE: <input type="checkbox"/> x10 <input type="checkbox"/> x20 <input type="checkbox"/> x30 THERAPEUTIC EXERCISES: 15 MIN <input type="checkbox"/> 30 MIN <input type="checkbox"/> 45 MIN <input type="checkbox"/> 60 MIN <input type="checkbox"/> SEE FLOW SHEET
IONTO	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LED <input type="checkbox"/> L LED <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> DEXAMETHASONE <input type="checkbox"/> ACETIC ACID <input type="checkbox"/> x1 TREATMENT <input type="checkbox"/> x2 TREATMENTS <input type="checkbox"/> x24 MINUTES <input type="checkbox"/>	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LED <input type="checkbox"/> L LED <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> DEXAMETHASONE <input type="checkbox"/> ACETIC ACID <input type="checkbox"/> x1 TREATMENT <input type="checkbox"/> x2 TREATMENTS <input type="checkbox"/> x24 MINUTES <input type="checkbox"/>
US	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LED <input type="checkbox"/> L LED <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> W/CM2: .50 1.00 1.50 2.00 2.50	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LED <input type="checkbox"/> L LED <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> W/CM2: .50 1.00 1.50 2.00 2.50
MANUAL	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LED <input type="checkbox"/> L LED <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> OTHER:	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LED <input type="checkbox"/> L LED <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> OTHER:
ANODYNE	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LED <input type="checkbox"/> L LED <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 30 MIN <input type="checkbox"/> 45 MIN <input type="checkbox"/> OTHER:	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LED <input type="checkbox"/> L LED <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 30 MIN <input type="checkbox"/> 45 MIN <input type="checkbox"/> OTHER:
MH/CP	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LED <input type="checkbox"/> L LED <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> OTHER:	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LED <input type="checkbox"/> L LED <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> OTHER:
OTHER	IFC x20 MINUTES <input type="checkbox"/> LASER <input type="checkbox"/> THERAPEUTIC ACTIVITY <input type="checkbox"/> OTHER <input type="checkbox"/>	IFC x20 MINUTES <input type="checkbox"/> LASER <input type="checkbox"/> THERAPEUTIC ACTIVITY <input type="checkbox"/> OTHER <input type="checkbox"/>
	Pt had no c/o pain TR	Pt had no c/o pain TR
	Cont c current rx J. Sgroi, RPT	Cont c current rx J. Sgroi, RPT

J. Sgroi, RPT

Kevin J. Sgroi, RPT

modality sheet

Name: 1/25/11

Date: 2/1/11

SUBJECTIVE	Pt was to pneumonia 6/07 & 1/08. May be to t coughing	Pt now stated today is first time s. No C/O w/it since last 7/07
OBJECTIVE	Mod t - muscle Tension Low Back	2BP ~ $\frac{3}{10}$
NEURO RE-ED	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LED <input type="checkbox"/> L LED <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> 30 MIN <input type="checkbox"/> OTHER:	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LED <input type="checkbox"/> L LED <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> 30 MIN <input type="checkbox"/> OTHER:
MASSAGE	TO MUSCULATURE OF: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LED <input type="checkbox"/> L LED <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> 30 MIN <input type="checkbox"/> 40 MIN <input type="checkbox"/> OTHER:	TO MUSCULATURE OF: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LED <input type="checkbox"/> L LED <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> 30 MIN <input type="checkbox"/> 40 MIN <input type="checkbox"/> OTHER:
TAPE/TE	KINESIO TAPE: $\times 1$ $\times 2$ $\times 3$ LEUKO TAPE: $\times 1$ $\times 2$ $\times 3$ THERAPEUTIC EXERCISES: 15 MIN <input type="checkbox"/> 30 MIN <input type="checkbox"/> 45 MIN <input type="checkbox"/> 60 MIN <input type="checkbox"/> SEE FLOW SHEET	KINESIO TAPE: $\times 1$ $\times 2$ $\times 3$ LEUKO TAPE: $\times 1$ $\times 2$ $\times 3$ THERAPEUTIC EXERCISES: 15 MIN <input type="checkbox"/> 30 MIN <input type="checkbox"/> 45 MIN <input type="checkbox"/> 60 MIN <input type="checkbox"/> SEE FLOW SHEET
IONTO	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LED <input type="checkbox"/> L LED <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> DEXAMETHASONE \times 1 TREATMENT \times 2 TREATMENTS \times 24 MINUTES \times	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LED <input type="checkbox"/> L LED <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> DEXAMETHASONE \times 1 TREATMENT \times 2 TREATMENTS \times 24 MINUTES \times
US	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LED <input type="checkbox"/> L LED <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> W/CM2: .5 \square 1.0 \square 1.5 \square 2.0 \square 2.5 \square	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LED <input type="checkbox"/> L LED <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> W/CM2: .5 \square 1.0 \square 1.5 \square 2.0 \square 2.5 \square
MANUAL	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LED <input type="checkbox"/> L LED <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> OTHER:	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LED <input type="checkbox"/> L LED <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> OTHER:
ANODYNE	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LED <input type="checkbox"/> L LED <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 30 MIN <input type="checkbox"/> 45 MIN <input type="checkbox"/> OTHER:	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LED <input type="checkbox"/> L LED <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 30 MIN <input type="checkbox"/> 45 MIN <input type="checkbox"/> OTHER:
MH/CP	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LED <input type="checkbox"/> L LED <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> OTHER:	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LED <input type="checkbox"/> L LED <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> OTHER:
OTHER	IFC \times 20 MINUTES \square LASER \square THERAPEUTIC ACTIVITY \square OTHER \square	IFC \times 20 MINUTES \square LASER \square THERAPEUTIC ACTIVITY \square OTHER \square
ASSESSMENT	Pt tol/k well & had no cr/pain t/k Cont & current pr J. Sgroi, PT	Pt tol/k well & 1/8D t to = to t/k Cont & current pr J. Sgroi, PT

Kevin J. Sgroi, RPT

Kevin J. Sgroi, RPT

modality sheet

Name: 1/11/11

Date: 1/18/11

SUBJECTIVE	Pt c/o Tingly (B) ft. Since last pt	Pt still c/o Tingly B ft- also c/o a sensation as if H ₂ O
OBJECTIVE	No r = a tinge goit	is running down the back of her leg
NEURO RE-ED	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIPS R UED L UED R LEG L LEG HANDB WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEED ANKLED FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> OTHER:	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIPS R UED L UED R LEG L LEG HANDB WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEED ANKLED FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> OTHER:
MASSAGE	TO MUSCULATURE OF: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIPS R UED L UED R LEG L LEG HANDB WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEED ANKLED FOOT <input type="checkbox"/> TIME: 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> 30 MIN <input type="checkbox"/> 40 MIN <input type="checkbox"/> OTHER:	TO MUSCULATURE OF: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIPS R UED L UED R LEG L LEG HANDB WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEED ANKLED FOOT <input type="checkbox"/> TIME: 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> 30 MIN <input type="checkbox"/> 40 MIN <input type="checkbox"/> OTHER:
TAPE/TE	KINESIO TAPE: <input type="checkbox"/> x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3 <input type="checkbox"/> LEUKO TAPE: <input type="checkbox"/> x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 MIN <input type="checkbox"/> 30 MIN <input type="checkbox"/> 45 MIN <input type="checkbox"/> 60 MIN <input type="checkbox"/> SEE FLOW SHEET	KINESIO TAPE: <input type="checkbox"/> x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3 <input type="checkbox"/> LEUKO TAPE: <input type="checkbox"/> x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 MIN <input type="checkbox"/> 30 MIN <input type="checkbox"/> 45 MIN <input type="checkbox"/> 60 MIN <input type="checkbox"/> SEE FLOW SHEET
IONTO	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIPS R UED L UED R LEG L LEG HANDB WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEED ANKLED FOOT <input type="checkbox"/> DEXAMETHASONE <input type="checkbox"/> ACETIC ACID <input type="checkbox"/> *1TREATMENT <input type="checkbox"/> *2TREATMENTS <input type="checkbox"/> *24 MINUTES <input type="checkbox"/>	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIPS R UED L UED R LEG L LEG HANDB WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEED ANKLED FOOT <input type="checkbox"/> DEXAMETHASONE <input type="checkbox"/> ACETIC ACID <input type="checkbox"/> *1TREATMENT <input type="checkbox"/> *2TREATMENTS <input type="checkbox"/> *24 MINUTES <input type="checkbox"/>
US	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIPS R UED L UED R LEG L LEG HANDB WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEED ANKLED FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> W/CM2: .5 <input type="checkbox"/> 1.0 <input type="checkbox"/> 1.5 <input type="checkbox"/> 2.0 <input type="checkbox"/> 2.5 <input type="checkbox"/>	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIPS R UED L UED R LEG L LEG HANDB WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEED ANKLED FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> W/CM2: .5 <input type="checkbox"/> 1.0 <input type="checkbox"/> 1.5 <input type="checkbox"/> 2.0 <input type="checkbox"/> 2.5 <input type="checkbox"/>
MANUAL	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIPS R UED L UED R LEG L LEG HANDB WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEED ANKLED FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> OTHER:	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIPS R UED L UED R LEG L LEG HANDB WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEED ANKLED FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> OTHER:
ANODYNE	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIPS R UED L UED R LEG L LEG HANDB WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEED ANKLED FOOT <input type="checkbox"/> TIME: 30 MIN <input type="checkbox"/> 45 MIN <input type="checkbox"/> OTHER:	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIPS R UED L UED R LEG L LEG HANDB WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEED ANKLED FOOT <input type="checkbox"/> TIME: 30 MIN <input type="checkbox"/> 45 MIN <input type="checkbox"/> OTHER:
M/H/CP	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIPS R UED L UED R LEG L LEG HANDB WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEED ANKLED FOOT <input type="checkbox"/> TIME: 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> OTHER:	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIPS R UED L UED R LEG L LEG HANDB WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEED ANKLED FOOT <input type="checkbox"/> TIME: 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> OTHER:
OTHER	IFC x20 MINUTES <input type="checkbox"/> LASER <input type="checkbox"/> THERAPEUTIC ACTIVITY <input type="checkbox"/> OTHER <input type="checkbox"/>	IFC x20 MINUTES <input type="checkbox"/> LASER <input type="checkbox"/> THERAPEUTIC ACTIVITY <input type="checkbox"/> OTHER <input type="checkbox"/>
ASSESSMENT	Pt still well c/o Tingly <input type="checkbox"/> P/T	Pt still well had no c/o ptosis to &
	Cont to current doc KJ Sgroi, PT	Cont to current doc KJ Sgroi, PT

Name: 7/14/10
Date:

Date: 7/14/10

SUBJECTIVE	Pt had no c/o and pain 4/14 since last Rx	Pt c/o pain over past 2 wk. also c/o Tiring of ft & leg.
OBJECTIVE	No tru muscle tension c/s / hand last	Pt stated after playing for a little while R/L E/C become very tired
NEURO RE-ED	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> OTHER:	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> OTHER:
MASSAGE	TO MUSCULATURE OF: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> 30 MIN <input type="checkbox"/> 40 MIN <input type="checkbox"/> OTHER: FA	TO MUSCULATURE OF: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> 30 MIN <input type="checkbox"/> 40 MIN <input type="checkbox"/> OTHER: FA
TAPE/TE	KINESIO TAPE: <input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 30 LEUKO TAPE: <input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 30 THERAPEUTIC EXERCISES: 15 MIN <input type="checkbox"/> 30 MIN <input type="checkbox"/> 45 MIN <input type="checkbox"/> 60 MIN <input type="checkbox"/> SEE FLOW SHEET	KINESIO TAPE: <input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 30 LEUKO TAPE: <input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 30 THERAPEUTIC EXERCISES: 15 MIN <input type="checkbox"/> 30 MIN <input type="checkbox"/> 45 MIN <input type="checkbox"/> 60 MIN <input type="checkbox"/> SEE FLOW SHEET
IONTO	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> DEXAMETHASONE <input type="checkbox"/> ACETIC ACID <input type="checkbox"/> x1 TREATMENT <input type="checkbox"/> x2 TREATMENTS <input type="checkbox"/> x24 MINUTES <input type="checkbox"/>	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> DEXAMETHASONE <input type="checkbox"/> ACETIC ACID <input type="checkbox"/> x1 TREATMENT <input type="checkbox"/> x2 TREATMENTS <input type="checkbox"/> x24 MINUTES <input type="checkbox"/>
US	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> W/CM2: .50 1.00 1.50 2.00 2.50	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> W/CM2: .50 1.00 1.50 2.00 2.50
MANUAL	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> OTHER: /	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> OTHER: /
ANODYNE	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 30 MIN <input type="checkbox"/> 45 MIN <input type="checkbox"/> OTHER: /	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 30 MIN <input type="checkbox"/> 45 MIN <input type="checkbox"/> OTHER: /
M/H/CP	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> OTHER: /	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UED <input type="checkbox"/> L UED <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> HAN <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TIME: 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> OTHER: /
OTHER	IFC <input type="checkbox"/> 20 MINUTES <input type="checkbox"/> LASER <input type="checkbox"/> THERAPEUTIC ACTIVITY <input type="checkbox"/> OTHER <input type="checkbox"/>	IFC <input type="checkbox"/> 20 MINUTES <input type="checkbox"/> LASER <input type="checkbox"/> THERAPEUTIC ACTIVITY <input type="checkbox"/> OTHER <input type="checkbox"/>
ASSESSMENT	Pt had no c/o pain	Pt had no c/o pain minor muscle tension low back /
PLAN	Cont to current Rx	Cont to current Rx

Kevin J. Sgroi, RPT

Kevin J. Sgroi, RPT

modality sheet

Name: [REDACTED]
Date: 11/30/10

Date: 12/19/10

SUBJECTIVE	PT c/o c/s upper thoracic pain. Pain = $\frac{3}{10}$	PT stated she had N/A's since last PT. No pain = upper thoracic
OBJECTIVE	Mod muscle Tension & c/s upper thoracic	Minor & muscle Tension to Back
NEURO RE-ED	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> HANEO <input type="checkbox"/> WRISTEO <input type="checkbox"/> ELBOWEO <input type="checkbox"/> KNEEO <input type="checkbox"/> ANKLEEO <input type="checkbox"/> FOOTEO TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> OTHER:	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> HANEO <input type="checkbox"/> WRISTEO <input type="checkbox"/> ELBOWEO <input type="checkbox"/> KNEEO <input type="checkbox"/> ANKLEEO <input type="checkbox"/> FOOTEO TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> OTHER:
MASSAGE	TO MUSCULATURE OF: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> HANEO <input type="checkbox"/> WRISTEO <input type="checkbox"/> ELBOWEO <input type="checkbox"/> KNEEO <input type="checkbox"/> ANKLEEO <input type="checkbox"/> FOOTEO TIME: 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> 30 MIN <input type="checkbox"/> 40 MIN <input type="checkbox"/> OTHER: PA	TO MUSCULATURE OF: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> HANEO <input type="checkbox"/> WRISTEO <input type="checkbox"/> ELBOWEO <input type="checkbox"/> KNEEO <input type="checkbox"/> ANKLEEO <input type="checkbox"/> FOOTEO TIME: 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> 30 MIN <input type="checkbox"/> 40 MIN <input type="checkbox"/> OTHER: FD
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MH/CP	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> HANEO <input type="checkbox"/> WRISTEO <input type="checkbox"/> ELBOWEO <input type="checkbox"/> KNEEO <input type="checkbox"/> ANKLEEO <input type="checkbox"/> FOOTEO TIME: 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> OTHER:	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> HANEO <input type="checkbox"/> WRISTEO <input type="checkbox"/> ELBOWEO <input type="checkbox"/> KNEEO <input type="checkbox"/> ANKLEEO <input type="checkbox"/> FOOTEO TIME: 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> OTHER:
OTHER	IFC $\times 20$ MINUTES <input type="checkbox"/> LASER <input type="checkbox"/> THERAPEUTIC ACTIVITY <input type="checkbox"/> OTHER <input type="checkbox"/>	IFC $\times 20$ MINUTES <input type="checkbox"/> LASER <input type="checkbox"/> THERAPEUTIC ACTIVITY <input type="checkbox"/> OTHER <input type="checkbox"/>
ASSESSMENT	PT still well 6/10 Pain & tension = 3/10	PT still well had no c/o H/O P/T
PLAN	Cont to current doc XJ Sgroi, RPT	Cont to current doc XJ Sgroi, RPT

Kevin J. Sgroi, RPT

Kevin J. Sgroi, RPT

modality sheet

Name: [REDACTED] Date: 10-26-10		Date: 11/9/10
SUBJECTIVE	<p>Pt mother stated [REDACTED] stated her leg felt felt like jelly</p>	<p>Pt had no c/o jelly like feeling in legs</p>
OBJECTIVE	2 twice T the wk	no antalgic part
NEURO RE-ED	TO: C/S D SHOULDERS D MID BACK D LOW BACK D HIP D R UED L UED R LEG L LEG HAND D WRIST D ELBOW D KNEED ANKLED FOOT D TIME: 10 MIN D 15 MIN D 20 MIN D 25 MIN D OTHER:	TO: C/S D SHOULDERS D MID BACK D LOW BACK D HIP D R UED L UED R LEG L LEG HAND D WRIST D ELBOW D KNEED ANKLED FOOT D TIME: 10 MIN D 15 MIN D 20 MIN D 25 MIN D OTHER:
MASSAGE	TO MUSCULATURE OF: C/S & SHOULDERS D MID BACK D LOW BACK D HIP D R UED L UED R LEG L LEG HAND D WRIST D ELBOW D KNEED ANKLED FOOT D TIME: 20 MIN D 25 MIN D 30 MIN D 40 MIN D OTHER: <i>PT</i>	TO MUSCULATURE OF: C/S & SHOULDERS D MID BACK D LOW BACK D HIP D R UED L UED R LEG L LEG HAND D WRIST D ELBOW D KNEED ANKLED FOOT D TIME: 20 MIN D 25 MIN D 30 MIN D 40 MIN D OTHER: <i>PT</i>
TAPE/TIE	KINESIO TAPE: x1 D x2 D x3 D LEUKO TAPE: x1 D x2 D x3 D THERAPEUTIC EXERCISES: 15 MIN D 30 MIN D 45 MIN D 60 MIN D SEE FLOW SHEET	KINESIO TAPE: x1 D x2 D x3 D LEUKO TAPE: x1 D x2 D x3 D THERAPEUTIC EXERCISES: 15 MIN D 30 MIN D 45 MIN D 60 MIN D SEE FLOW SHEET
IONO	TO: C/S D SHOULDERS D MID BACK D LOW BACK D HIP D R UED L UED R LEG L LEG HAND D WRIST D ELBOW D KNEED ANKLED FOOT D DEXAMETHASONE D ACETIC ACID D x1 TREATMENT D x2 TREATMENTS D x24 MINUTES D	TO: C/S D SHOULDERS D MID BACK D LOW BACK D HIP D R UED L UED R LEG L LEG HAND D WRIST D ELBOW D KNEED ANKLED FOOT D DEXAMETHASONE D ACETIC ACID D x1 TREATMENT D x2 TREATMENTS D x24 MINUTES D
US	TO: C/S D SHOULDERS D MID BACK D LOW BACK D HIP D R UED L UED R LEG L LEG HAND D WRIST D ELBOW D KNEED ANKLED FOOT D TIME: 10 MIN D 15 MIN D 20 MIN D 25 MIN D W/CM2: .50 D 1.00 D 1.50 D 2.00 D 2.50	TO: C/S D SHOULDERS D MID BACK D LOW BACK D HIP D R UED L UED R LEG L LEG HAND D WRIST D ELBOW D KNEED ANKLED FOOT D TIME: 10 MIN D 15 MIN D 20 MIN D 25 MIN D W/CM2: .50 D 1.00 D 1.50 D 2.00 D 2.50
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ANODYNE	TO: C/S D SHOULDERS D MID BACK D LOW BACK D HIP D R UED L UED R LEG L LEG HAND D WRIST D ELBOW D KNEED ANKLED FOOT D TIME: 30 MIN D 45 MIN D OTHER:	TO: C/S D SHOULDERS D MID BACK D LOW BACK D HIP D R UED L UED R LEG L LEG HAND D WRIST D ELBOW D KNEED ANKLED FOOT D TIME: 30 MIN D 45 MIN D OTHER:
MI/CP	TO: C/S D SHOULDERS D MID BACK D LOW BACK D HIP D R UED L UED R LEG L LEG HAND D WRIST D ELBOW D KNEED ANKLED FOOT D TIME: 20 MIN D 25 MIN D OTHER:	TO: C/S D SHOULDERS D MID BACK D LOW BACK D HIP D R UED L UED R LEG L LEG HAND D WRIST D ELBOW D KNEED ANKLED FOOT D TIME: 20 MIN D 25 MIN D OTHER:
OTHER	IFC x20 MINUTES D LASER D THERAPEUTIC ACTIVITY D OTHER:	IFC x20 MINUTES D LASER D THERAPEUTIC ACTIVITY D OTHER:
ASSESSMENT	<p>Pt tol R well had no c/o pain R</p>	<p>Pt tol R well had no c/o pain R</p>
PLAN	Cont to currnt rx <i>Dr. J. Sgroi, PT</i>	Cont to currnt rx <i>Dr. J. Sgroi, PT</i>

Kevin J. Sgroi, RPT

Kevin J. Sgroi, RPT

modality sheet

SUBJECTIVE	Name: [REDACTED] Date: 10/2/16	Date: 10/2/16
OBJECTIVE	SEE IE	No signif + S in muscle tension
NEURO REF-ED	TO: C/S D SHOULDERS MID BACKD LOW BACKD HIPD R UED L UED R LED L LED HANDD WRISTD ELBOWD KNEED ANKLED FOOTD TIME: 10 MIN D 15 MIN D 20 MIN D 25 MIN D OTHER:	TO: C/S D SHOULDERS MID BACKD LOW BACKD HIPD R UED L UED R LED L LED HANDD WRISTD ELBOWD KNEED ANKLED FOOTD TIME: 10 MIN D 15 MIN D 20 MIN D 25 MIN D OTHER:
MASSAGE	TO MUSCULATURE OF: C/S D SHOULDERS MID BACKD LOW BACKD HIPD R UED L UED R LED L LED HANDD WRISTD ELBOWD KNEED ANKLED FOOTD TIME: 20 MIN D 25 MIN D 30 MIN D 40 MIN D OTHER:	TO MUSCULATURE OF: C/S D SHOULDERS MID BACKD LOW BACKD HIPD R UED L UED R LED L LED HANDD WRISTD ELBOWD KNEED ANKLED FOOTD TIME: 20 MIN D 25 MIN D 30 MIN D 40 MIN D OTHER:
TAPING	KINESIO TAPE: x10 x20 x30 LEUKO TAPE: x10 x20 x30 THERAPEUTIC EXERCISES: 15 MIN D 30 MIN D 45 MIN D 60 MIN D SEE FLOW SHEET	KINESIO TAPE: x10 x20 x30 LEUKO TAPE: x10 x20 x30 THERAPEUTIC EXERCISES: 15 MIN D 30 MIN D 45 MIN D 60 MIN D SEE FLOW SHEET
IONO	TO: C/S D SHOULDERS MID BACKD LOW BACKD HIPD R UED L UED R LED L LED HANDD WRISTD ELBOWD KNEED ANKLED FOOTD DEXAMETHASONE: ACETIC ACID: x1 TREATMENT x2 TREATMENTS D 24 MINUTES D	TO: C/S D SHOULDERS MID BACKD LOW BACKD HIPD R UED L UED R LED L LED HANDD WRISTD ELBOWD KNEED ANKLED FOOTD DEXAMETHASONE: ACETIC ACID: x1 TREATMENT x2 TREATMENTS D 24 MINUTES D
US	TO: C/S D SHOULDERS MID BACKD LOW BACKD HIPD R UED L UED R LED L LED HANDD WRISTD ELBOWD KNEED ANKLED FOOTD TIME: 10 MIN D 15 MIN D 20 MIN D 25 MIN D W/CM2: .5D 1.0D 1.5D 2.0D 2.5D	TO: C/S D SHOULDERS MID BACKD LOW BACKD HIPD R UED L UED R LED L LED HANDD WRISTD ELBOWD KNEED ANKLED FOOTD TIME: 10 MIN D 15 MIN D 20 MIN D 25 MIN D W/CM2: .5D 1.0D 1.5D 2.0D 2.5D
MANUAL	TO: C/S D SHOULDERS MID BACKD LOW BACKD HIPD R UED L UED R LED L LED HANDD WRISTD ELBOWD KNEED ANKLED FOOTD TIME: 10 MIN D 15 MIN D 20 MIN D 25 MIN D OTHER:	TO: C/S D SHOULDERS MID BACKD LOW BACKD HIPD R UED L UED R LED L LED HANDD WRISTD ELBOWD KNEED ANKLED FOOTD TIME: 10 MIN D 15 MIN D 20 MIN D 25 MIN D OTHER:
ANODYNE	TO: C/S D SHOULDERS MID BACKD LOW BACKD HIPD R UED L UED R LED L LED HANDD WRISTD ELBOWD KNEED ANKLED FOOTD TIME: 30 MIN D 45 MIN D OTHER:	TO: C/S D SHOULDERS MID BACKD LOW BACKD HIPD R UED L UED R LED L LED HANDD WRISTD ELBOWD KNEED ANKLED FOOTD TIME: 30 MIN D 45 MIN D OTHER:
NCNP	TO: C/S D SHOULDERS MID BACKD LOW BACKD HIPD R UED L UED R LED L LED HANDD WRISTD ELBOWD KNEED ANKLED FOOTD TIME: 20 MIN D 25 MIN D OTHER:	TO: C/S D SHOULDERS MID BACKD LOW BACKD HIPD R UED L UED R LED L LED HANDD WRISTD ELBOWD KNEED ANKLED FOOTD TIME: 20 MIN D 25 MIN D OTHER:
OTHER	IFC x20 MINUTES D LASER x 15 min SHD / looked THERAPEUTIC ACTIVITY D OTHER D	IFC x20 MINUTES D LASER THERAPEUTIC ACTIVITY D OTHER D
ASSESSMENT	PT talk well sent Tenderness & leg D 50% PR	PT talk well C/P pain & to = 2 PR
PLAN	Cont & current doc St. Vojna, PT	Cont & current doc D. B. May, PT

10/06/2010 WED 12:38 FAX 208 292 5441 LAKESIDE PEDIATRICS

001/005

REFERRAL REQUEST

Lakeside Pediatric & Adolescent Medicine, PLLC
980 W. Ironwood Drive, Suite 302
Coeur d' Alene, Idaho 83814
Phone (208) 292-5437 Fax (208) 292-5441

Date: 10/04/10

Referring Provider: Ronda L. Westcott, MD

Patient Name: [REDACTED] Age: [REDACTED] D.O.B: [REDACTED]

Parent/Guardian Name: Wayne Bryant

Home Phone #: (208) 762-5619

Insurance Policy Holder: Bryant, Wayne

Insurance Carrier: Blue Cross of Idaho & Medicaid

Insurance ID #: XMH970191763 & 0001643066 Group #: 10021090

Healthy Connection #: 806389000

Referred To: Joshua Tree Physical Therapy

Phone Number: 208-772-9774 Fax Number: 208-772-9564

DIAGNOSIS: 742.59 – *Spinal Cord Anomaly NEC*

Comments: Evaluation of leg fatigue and right sided intermittent tingling.

Requested Services: Evaluation, management, and physical therapy as needed.

Length of Referral: Effective 10/04/2010 – 10/04/2011

10/02/005

10/04/2010 4:13 PM

Page 1

Patient Report By Patient Number
LAKESIDE PEDIATRIC & ADOLESCENT MEDICINE

Selections:

Registered: 01/01/1990 - 10/04/2010
 Patients: [REDACTED]
 Accounts: 640
 Alerts: Excluded
 Notes: Excluded
 IDs: Excluded

808			Default Account: 640	Class: Y																							
			SSN: [REDACTED]	Sex: Female	Emp Status: U																						
			Chart #: [REDACTED]	DOB: [REDACTED]	Employee ID: [REDACTED]																						
			Registered: 10/09/2007	Race / Ethnicity: C /	Employer: [REDACTED]																						
			First Visit: 10/09/2007	Lang: ENG																							
			Last Visit: 09/20/2010	Marital: Single																							
			Email: [REDACTED]	Consent: Yes	Assigned: Westcott, MD, Ronda L.																						
			Home: (208) 762-5619	Referral Src: [REDACTED]	Referring: [REDACTED]																						
			Work: [REDACTED]																								
Emergency Contact:		Bryant, Caren Email: [REDACTED] Pat Rel to Contact: Grandchild Home: (208) 651-6499 Bryant, April Work: [REDACTED]																									
Legal Guardian:		Bryant, April Email: [REDACTED] Pat Rel to Guardian: Child Home: (208) 762-4281 Work: (208) 772-2490 Mobile: (208) 651-5853																									
Accounts:		<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;">Number</th> <th style="width: 15%;">Guarantor</th> <th style="width: 15%;">Acct Finance Grp</th> <th style="width: 15%;">Default</th> <th style="width: 15%;">Status</th> <th style="width: 15%;">Balance</th> </tr> </thead> <tbody> <tr> <td>640</td> <td>Bryant, Wayne</td> <td>STNDRD</td> <td>Y</td> <td>Active</td> <td>51.52</td> </tr> </tbody> </table>					Number	Guarantor	Acct Finance Grp	Default	Status	Balance	640	Bryant, Wayne	STNDRD	Y	Active	51.52									
Number	Guarantor	Acct Finance Grp	Default	Status	Balance																						
640	Bryant, Wayne	STNDRD	Y	Active	51.52																						
Ins. Policies:		<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;">Plan</th> <th style="width: 15%;">Group</th> <th style="width: 15%;">Claim Member IDs</th> <th style="width: 15%;">Status</th> <th style="width: 15%;">Subscriber</th> <th style="width: 15%;">Relation to Sub</th> <th style="width: 15%;">Accept Assign</th> </tr> </thead> <tbody> <tr> <td>1 BC01 - Blue Cross of Idaho</td> <td></td> <td>XMH970191763</td> <td>Active</td> <td>Bryant, Wayne</td> <td>Child</td> <td>Y</td> </tr> <tr> <td>2 MCD01 - Medicaid</td> <td></td> <td>0001643066</td> <td>Active</td> <td>[REDACTED]</td> <td>Self</td> <td>Y</td> </tr> </tbody> </table>					Plan	Group	Claim Member IDs	Status	Subscriber	Relation to Sub	Accept Assign	1 BC01 - Blue Cross of Idaho		XMH970191763	Active	Bryant, Wayne	Child	Y	2 MCD01 - Medicaid		0001643066	Active	[REDACTED]	Self	Y
Plan	Group	Claim Member IDs	Status	Subscriber	Relation to Sub	Accept Assign																					
1 BC01 - Blue Cross of Idaho		XMH970191763	Active	Bryant, Wayne	Child	Y																					
2 MCD01 - Medicaid		0001643066	Active	[REDACTED]	Self	Y																					
Extended Info:		<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;">Description</th> <th style="width: 15%;">Value</th> </tr> </thead> <tbody> <tr> <td>Dad's Nickname</td> <td>Wayne Bryant</td> </tr> <tr> <td>Mom's Nickname</td> <td>April Bryant</td> </tr> <tr> <td>Patient's Nickname</td> <td>[REDACTED]</td> </tr> </tbody> </table>					Description	Value	Dad's Nickname	Wayne Bryant	Mom's Nickname	April Bryant	Patient's Nickname	[REDACTED]													
Description	Value																										
Dad's Nickname	Wayne Bryant																										
Mom's Nickname	April Bryant																										
Patient's Nickname	[REDACTED]																										

Total Patients: 1

10/06/2010 WED 12:39 FAX 208 292 5441 LAKESIDE PEDIATRICS

2003/005

Patient: 808 - [REDACTED]
DOB: [REDACTED]
SSN: [REDACTED]

Date: 10/04/2010 14:50
Provider: Westcott, MD, Ronda L.
Encounter: Acute Visit

ACTIVE PROBLEMS

- SPINAL CORD ANOMALY NEC - tethered cord s/p surgical repair at Arnold Chiari Institute. Had Lumboperitoneal shunt, but tied off 6/09. Syrinx - down 30%. Due for shunt removal in spring 2010
- Urinary Calculus - Off hydrochlorothiazide (due to nephrocalcinosis on ultrasound 10/09), off Acetazolamide; Renal Ultrasound annually; Nephrology annually.

CHIEF COMPLAINT

The Chief Complaint is: Bladder issues and tingling in hands.

HISTORY OF PRESENT ILLNESS

[REDACTED] is a [REDACTED] year old female.
• Patient accompanied by mother.
Tingling in her right hand off and on (becoming more frequent), started 4 months ago. Not occurring on the left side. Sometimes has similar symptoms in feet, though again usually one sided.

Intermittent pain in both legs, usually exacerbated by activity - or will just be more fatigued than expected.

Still often has small amt of leaking urine after she voids - has tried change in position (sitting backward on potty), but no improvement in symptoms. Will often change underwear as they are wet. No burning with urination, no accidents. No bedwetting.

CURRENT MEDICATION

- Sodium Fluoride 2.2 (1 F) MG CHEW, , 90 days, 3 refills, Take one tab po qd

PAST MEDICAL/SURGICAL HISTORY

Reported History:

Medications: Taking medication HCTH, Fluoride, Vit D recommended.

Physical Trauma: Surgical incision.

Diagnosis History:

Nephrolithiasis.

Neurologic disorder Arnold Chiari malformation with tethered cord, s/p release. Spinal syrinx; LP shunt

ALLERGIES

- Latex Reaction: precaution

FAMILY HISTORY

Maternal cousin with Marfan Syndrome

REVIEW OF SYSTEMS

10/06/2010 WED 12:39 FAX 208 292 5441 LAKESIDE PEDIATRICS

004/005

Patient: 808 - [REDACTED]
 DOB: [REDACTED]
 SSN: [REDACTED]

Date: 10/04/2010 14:50
 Provider: Westcott, MD, Ronda L.
 Encounter: Acute Visit

Systemic: No lethargy. No fever.
 Eyes: No purulent discharge from eyes and no bloodshot eyes.
 Otolaryngeal: No discharge from the ears and no nasal discharge or congestion.
 Pulmonary: No cough and no wheezing or dyspnea.
 Gastrointestinal: Normal appetite, no vomiting, and no diarrhea.
 Skin: No skin lesions.

PHYSICAL FINDINGS

• Vitals taken 10/04/2010 02:50 pm

wt. was 46-8

Pulse Rate-Sitting

100 bpm

Respiration Rate

24 per min

Temp-Temporal

98.3 F

Weight

46 lbs 8 oz

General Appearance:

◦ Alert. ◦ In no acute distress.

Eyes:

General/bilateral:

External: ◦ Conjunctiva exhibited no abnormalities. ◦ No discharge from the conjunctiva.

Optic Disc: ◦ Showed no papilledema.

Ears:

Right Ear:

Tympanic Membrane: • Examined and normal.

Left Ear:

Tympanic Membrane: • Examined and normal.

Nose:

General/bilateral:

Discharge: ◦ No nasal discharge seen.

Pharynx:

Oropharynx: ◦ Tonsils were not swollen. ◦ Tonsils were not erythematous. ◦ Tonsils showed no exudate. ◦ Not inflamed.

Lymph Nodes:

◦ Anterior cervical lymph nodes were not enlarged.

Lungs:

◦ Clear to auscultation.

Cardiovascular:

Heart Sounds: ◦ S1 normal. ◦ S2 normal.

Murmurs: ◦ No murmurs were heard.

Abdomen:

Palpation: ◦ No abdominal tenderness, was soft and non-distended.

Neurological:

Cranial Nerves: ◦ Normal.

Motor: ◦ Strength was normal.

Coordination / Cerebellum: ◦ No coordination/cerebellum abnormalities were noted.

Gait And Stance: ◦ Normal.

Reflexes: • Right knee jerk reflex unable to illicit. • Left knee jerk reflex normal.

Skin:

• Skin: no rash. Brisk capillary refill.

10/06/2010 WED 12:39 FAX 208 292 5441 LAKESIDE PEDIATRICS

0005/005

Patient: 808 - [REDACTED]
DOB: [REDACTED]
SSN: [REDACTED]

Date: 10/04/2010 14:50
Provider: Westcott, MD, Ronda L.
Encounter: Acute Visit

TESTS

Urinalysis Was Performed:

Urinalysis Results:	Value
Urine pH	6
Urine specific gravity	1025
Urine occult blood	1 +

Normal urine protein, negative for glucose, negative for bilirubin, negative for ketones, negative for nitrate, and negative for leukocyte esterase.

ASSESSMENT

- Primary diagnosis of post-void dribbling
- Peripheral neuropathy vs weakened muscles; vague history, normal neuro exam

PLAN

- SPINAL CORD ANOMALY NEC
Referral: Physical Therapy

Patient with past normal urodynamic evaluation; symptoms of post void dribbling still seem due to external anatomy issues rather than inability to completely void. Monitor clinically - follow up with Urology in Seattle when there next.

Referred back to PT for further evaluation of weakened muscles vs mild peripheral neuropathy. Advised MVI daily and working to increase K in diet.

Annual follow up with Neurosurgery in Seattle.

Ronda L. Westcott, MD

Electronically signed by: Ronda Westcott Date: 10/05/2010 17:14

Joshua Tree Physical Therapy

REGISTRATION FORM

This information is necessary so that we may serve your needs
 Information will not be released without your written consent

Today's date: 10/12/10

Referred By: Westcott

PATIENT INFORMATION

Patient's last name: [REDACTED]	First: [REDACTED]	Middle: [REDACTED]	<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	Marital status (circle one)
			<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	Single / Mar / Div / S / Wid

Birth date: [REDACTED]	Age: [REDACTED]	Sex: [REDACTED]	Social Security #: [REDACTED]	Home phone #: 651-5853
		OM OF		

Street address:

2417 e. St James

P.O. box: [REDACTED]	City: Hayden	State: Id	ZIP Code: 83835
Occupation: [REDACTED]	Employer: [REDACTED]	Employer phone#: [REDACTED]	

Referring Physician: [REDACTED]	Referring Physician Phone#: [REDACTED]	Primary Physician: Westcott
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Primary Physician Phone#: 292-5437	Date of Injury: [REDACTED]	Type of Injury: Work Related <input type="checkbox"/> MVA <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/>
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How did your injury/ symptoms occur? Surgical error in NY	If MVA please provide the following: Claim #: [REDACTED] Insurance co.: [REDACTED] Address: [REDACTED]
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INSURANCE INFORMATION Same Blue Cross + ID M

Subscriber's name: [REDACTED]	Birth date: 1/23/78	Address (if different): [REDACTED]	Home phone #: [REDACTED]
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Subscriber's S.S.#: [REDACTED]	Group #: [REDACTED]	Policy #: [REDACTED]	Co-pay \$ [REDACTED]
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Occupation: [REDACTED]	Employer: [REDACTED]	Employer address: [REDACTED]	Employer phone #: [REDACTED]
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Patient's relationship: [REDACTED]	<input type="checkbox"/> Self	<input type="checkbox"/> Child	<input type="checkbox"/> Spouse	<input type="checkbox"/> Other	[REDACTED]
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Name of secondary insurance: [REDACTED]	Subscriber's name: [REDACTED]	Group #: [REDACTED]	Policy #: [REDACTED]
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Patient's relationship to subscriber	<input type="checkbox"/> Self	<input checked="" type="checkbox"/> Child	<input type="checkbox"/> Spo.	<input type="checkbox"/> Other	
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IN CASE OF EMERGENCY

Name of local friend or relative (living at different residence)	Relationship:	Home phone #:	Work phone #:

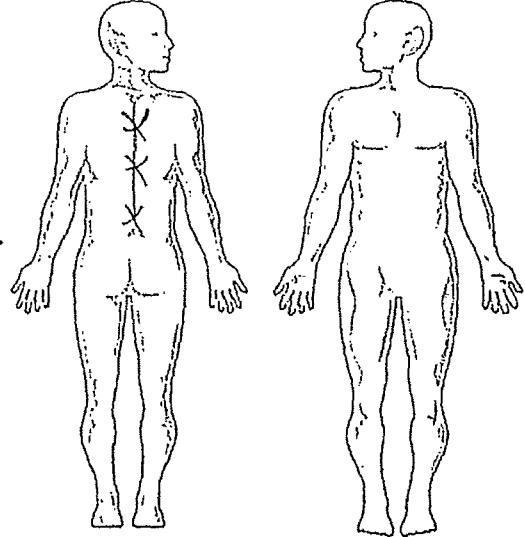
Authorization for release of information: I authorize Kevin J. Sgroi, RPT, to release all medical information requested by my health insurance carrier, Medicare or any other third-party payers. I authorize Kevin J. Sgroi, RPT, to release all medical information to my referring physician and my primary (family) physician. I authorize Kevin J. Sgroi, RPT, to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Kevin J. Sgroi, RPT.

Assignment of Benefits: I request that payment of authorized insurance benefits be made on my behalf Kevin J. Sgroi, RPT. I agree that these provisions will remain in effect until I provide written revocation to Kevin J. Sgroi, RPT. I further agree that should my insurance carrier and /or health plan administer deem that my treatment, in full or part is not covered that I am responsible for all charges incurred as a result of treatment rendered by Kevin J. Sgroi, RPT and associates.

<i>Paul Bryant</i>	10/12/10
Patient/Guardian signature	Date

Referral Information : Initial Referral Received	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Length of service approved:	Follow up date:
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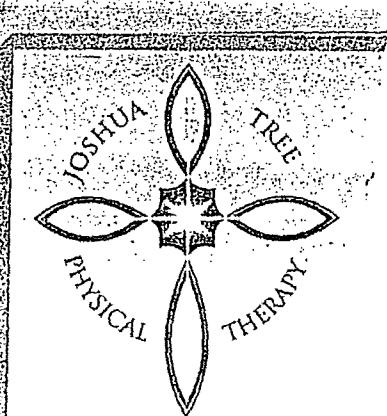
Joshua Tree Physical Therapy**CONFIDENTIAL INFORMATION**

Do you have a history of the following?		
Have you ever received <i>massage therapy</i> ? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> accident	<input checked="" type="checkbox"/> surgery
	<input type="checkbox"/> neck pain	<input type="checkbox"/> fibromyalgia
Type of massage experienced: <input type="checkbox"/> Deep Tissue <input type="checkbox"/> Swedish <input type="checkbox"/> Other	<input type="checkbox"/> whiplash	<input type="checkbox"/> carpal tunnel
	<input type="checkbox"/> decreased range of motion	<input type="checkbox"/> mastectomy
Are you currently taking medication? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> broken bones	<input type="checkbox"/> breast augmentation
	<input type="checkbox"/> sciatica	<input type="checkbox"/> diabetes
Describe the medication you are taking below. 1. 2. 3. 4. 5.	<input type="checkbox"/> sprains	<input type="checkbox"/> varicose veins
	<input type="checkbox"/> seizures	<input type="checkbox"/> high blood pressure
Are you pregnant? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> abdominal pain	<input type="checkbox"/> stroke
	<input type="checkbox"/> nervous tension	<input type="checkbox"/> heart attack
Have you consumed alcohol in the past 24-hours? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> arthritis, bursitis or gout	<input type="checkbox"/> cancer
	<input type="checkbox"/> allergies to oils or perfumes	<input type="checkbox"/> colitis
What are your goals and expectations for this receiving physical therapy?	<input type="checkbox"/> wear contacts	<input type="checkbox"/> HIV
	<input type="checkbox"/> scoliosis	<input type="checkbox"/> other
Do you have any of the following today?		
	<input type="checkbox"/> sunburn	<input type="checkbox"/> open cuts, burns, bruises
	<input type="checkbox"/> inflammation	<input type="checkbox"/> irritated skin rash
	<input checked="" type="checkbox"/> severe pain	<input type="checkbox"/> poison ivy
	<input type="checkbox"/> headache	<input type="checkbox"/> cold/flu
Please Indicate with an (X), the areas you are feeling discomfort		
		

Joshua Tree Physical Therapy
PRIVACY PRACTICES ACKNOWLEDGEMENT

I have been provided a copy of and have read the Privacy Practice Notice. I understand my rights contained in the notice. By way of my signature, I consent Joshua Tree Physical Therapy to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

NAME	[REDACTED]	DATE OF BIRTH	[REDACTED]
SIGNATURE:	[REDACTED]		
	DATE: 12/30/63		



JOSHUA TREE PHYSICAL THERAPY

Initial Evaluation

Date: October 15, 2010.

Physician: Dr. Westcott

Re: [REDACTED]

Diagnosis: Mid/ Low back pain.

Dear Dr. Westcott:

Thank you for referring your patient to Joshua Tree Physical Therapy. Upon initial evaluation the following was determined.

History: The patient is a [REDACTED] female with complaints of mid and low back pain. At rest pain is rated at approximately 2/10 to 3/10 and increases to approximately 5/10 to 6/10 with activities of daily living. Patient does complain of radiating pain into the bilateral lower lower extremities. However, the patient does not complain of numbness and tingling into the bilateral lower extremities. Patient does complain of occasional headaches these are rated as moderate to severe.

PMH: Patient has been diagnosed with Chiari. Patient has undergone several surgical procedures secondary to this diagnosis. There has been a duraplasty patch surgically implanted at the base of the child's skull. She also has a lumbar shunt to enhance the flow of cerebral spinal fluid. Patient also had surgery for removal of vertebrae C1 and L3 through L5. Patient also has been diagnosed with hypercalcemic production and is taking medication HCTC for this condition.

Objective:

Active Range of Motion

Loss of Movement:

Lumbar flexion:	Moderate with severe complaints of low back pain
Lumbar extension:	Minimal with complaints of low back pain.
Lateral flexion left:	Minimal with complaints of tightness and pulling
Lateral flexion right:	Minimal with complaints of tightness and pulling
Rotation right:	None without complaints of pain
Rotation left:	None without complaints of pain

Manual Muscle Test:

Left Right.

Quadriceps:	4/5	4+/5
Hamstrings:	4/5	4+/5
Ankle plantarflexion:	4/5	4+/5
Dorsiflexion:	4/5	4+/5
Dorsi flexion great toe:	4/5	4+/5

Objective:

AROM.

Left

Right.

Cervical flexion:	80 %	80 % of normal
Cervical extension:		90 % of normal.
Lateral flexion:	80 %	80 %.
Rotation:	90 %	90 %.
Shoulder AROM:	180°	180°

8475 NORTH GOVERNMENT WAY, HAYDEN, IDAHO 83815

PHONE: 208-772-9774 FAX: 208-772-9564

(flexion)

Observation: Patient is able to perform bilateral heel raises equally however, when performing heel raises unilaterally the patient had more difficulty raising the heel on right when compared to left.

Reflexes: Left Achilles and patella reflexes are within normal limits. Right Achilles and patella reflexes are moderately diminished.

Palpation: There are noted numerous trigger points and tonic muscle spasms throughout the cervical, thoracic, and lumbar paraspinals.

Treatment Program: The patient will receive education on proper body mechanics and posture. Treatment and modalities will include, anodyne light treatment, medical massage, neuromuscular reeducation, therapeutic laser, therapeutic exercises, and home exercise program.

Assessment:

Problem List:

- Complaints of pain at rest.
- Complaints of pain with activities of daily living.
- Tonic muscle spasms noted throughout all paraspinals.
- Decreased active range of motion cervical spine and lumbar spine.
- Complaints of constant headaches

Short-Term Goals: Four weeks

- Decrease complaints of pain at rest by 50%.
- Decrease tonic muscle spasms by 50%.
- Increase active range of motion cervical and lumbar spine to WNL.

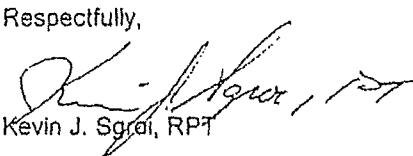
Long-term goals: Eight weeks.

- Decrease complaints of pain at rest to 0/10.
- Patient to perform activities daily living without complaints of pain.
- Decrease tonic muscle spasms by 90%.
- Patient to be independent with supervision in home exercise program.

Plan of Care: The patient will receive the above treatment program two to three times a week for up to eight weeks. The treatment program will be upgraded and modified as per physician's recommendations and as patient tolerates to achieve the above goals.

Once, again thank you for referring your patient to Joshua Tree Physical Therapy. If you have any questions or recommendations about your patient's care please contact me at your earliest convenience.

Respectfully,


Kevin J. Sgrai, RPT

Name: 10/12/10

Date: 10/21/10

SUBJECTIVE	SEE IE	PT c/o low back local pain = $\frac{2}{10}$
OBJECTIVE	SEE IE	No signs/symptoms
NEURO REFED	TO: C/S D SHOULDERS/ MID BACK/ LOW BACK/ HIP/ R UED L UED R LEG L LEG HANDS WRIST/ ELBOW/ KNEED/ ANKLED/ FOOTD TIME: 10 MIN D 15 MIN D 20 MIN D 25 MIN D OTHER:	TO: C/S D SHOULDERS/ MID BACK/ LOW BACK/ HIP/ R UED L UED R LEG L LEG HANDS WRIST/ ELBOW/ KNEED/ ANKLED/ FOOTD TIME: 10 MIN D 15 MIN D 20 MIN D 25 MIN D OTHER:
MESSAGE	TO MUSCULATURE OF: C/S D SHOULDERS/ MID BACK/ LOW BACK/ HIP/ R UED L UED R LEG L LEG HANDS WRIST/ ELBOW/ KNEED/ ANKLED/ FOOTD TIME: 20 MIN D 25 MIN D 30 MIN D 40 MIN D OTHER:	TO MUSCULATURE OF: C/S D SHOULDERS/ MID BACK/ LOW BACK/ HIP/ R UED L UED R LEG L LEG HANDS WRIST/ ELBOW/ KNEED/ ANKLED/ FOOTD TIME: 20 MIN D 25 MIN D 30 MIN D 40 MIN D OTHER:
TAPE/TE	KINESIO TAPE: x10 x20 x30 LEUKO TAPE: x10 x20 x30 THERAPEUTIC EXERCISES: 15 MIN D 30 MIN D 45 MIN D 60 MIN D SEE FLOW SHEET	KINESIO TAPE: x10 x20 x30 LEUKO TAPE: x10 x20 x30 THERAPEUTIC EXERCISES: 15 MIN D 30 MIN D 45 MIN D 60 MIN D SEE FLOW SHEET
ORTHO	TO: C/S D SHOULDERS/ MID BACK/ LOW BACK/ HIP/ R UED L UED R LEG L LEG HANDS WRIST/ ELBOW/ KNEED/ ANKLED/ FOOTD DEXAMETHASONE: ACETIC ACID: x1 TREATMENT D x2 TREATMENTS D x24 MINUTES D	TO: C/S D SHOULDERS/ MID BACK/ LOW BACK/ HIP/ R UED L UED R LEG L LEG HANDS WRIST/ ELBOW/ KNEED/ ANKLED/ FOOTD DEXAMETHASONE: ACETIC ACID: x1 TREATMENT D x2 TREATMENTS D x24 MINUTES D
LS	TO: C/S D SHOULDERS/ MID BACK/ LOW BACK/ HIP/ R UED L UED R LEG L LEG HANDS WRIST/ ELBOW/ KNEED/ ANKLED/ FOOTD TIME: 10 MIN D 15 MIN D 20 MIN D 25 MIN D W/CM12: 3.0 1.0 D 1.5 D 2.0 D 2.5 D	TO: C/S D SHOULDERS/ MID BACK/ LOW BACK/ HIP/ R UED L UED R LEG L LEG HANDS WRIST/ ELBOW/ KNEED/ ANKLED/ FOOTD TIME: 10 MIN D 15 MIN D 20 MIN D 25 MIN D W/CM12: 3.0 1.0 D 1.5 D 2.0 D 2.5 D
MANUAL	TO: C/S D SHOULDERS/ MID BACK/ LOW BACK/ HIP/ R UED L UED R LEG L LEG HANDS WRIST/ ELBOW/ KNEED/ ANKLED/ FOOTD TIME: 10 MIN D 15 MIN D 20 MIN D 25 MIN D OTHER:	TO: C/S D SHOULDERS/ MID BACK/ LOW BACK/ HIP/ R UED L UED R LEG L LEG HANDS WRIST/ ELBOW/ KNEED/ ANKLED/ FOOTD TIME: 10 MIN D 15 MIN D 20 MIN D 25 MIN D OTHER:
ANODINE	TO: C/S D SHOULDERS/ MID BACK/ LOW BACK/ HIP/ R UED L UED R LEG L LEG HANDS WRIST/ ELBOW/ KNEED/ ANKLED/ FOOTD TIME: 30 MIN D 45 MIN D OTHER:	TO: C/S D SHOULDERS/ MID BACK/ LOW BACK/ HIP/ R UED L UED R LEG L LEG HANDS WRIST/ ELBOW/ KNEED/ ANKLED/ FOOTD TIME: 30 MIN D 45 MIN D OTHER:
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OTHER	IPC x20 MINUTES D LASERS D x 15 min SPT off/locked THERAPEUTIC ACTIVITIES: PROGRAM A OTHER:	IPC x20 MINUTES D LASERS D THERAPEUTIC ACTIVITIES: D OTHER:
ASSESSMENT	PT able to walk short distances slowly at 50% PR.	PT able to walk C/P pain 1 to $\frac{2}{10}$ PR
PLAN	Continue current rx St. Regis, 1/14	Continue current rx St. Regis, 1/14 56

NAME: [REDACTED]		SSN: [REDACTED]	DATE: [REDACTED]
Subjective	SEE TE		
Objective	SEE TE		
NEURO Rx-Es	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input checked="" type="checkbox"/> 25 min <input type="checkbox"/> OTHER: <i>error</i>	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 10 min <input type="checkbox"/> 15 min <input type="checkbox"/> 20 min <input type="checkbox"/> OTHER	
Massage	To Musculature of: C/S <input checked="" type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Hip <input type="checkbox"/> Low Back <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Wrist <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input checked="" type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER: <i>SP</i>	To Musculature of: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Wrist <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> 25 min <input type="checkbox"/> 30 min <input type="checkbox"/> OTHER:	
Tape/TE	Kinesio tape: <input type="checkbox"/> x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> Leuko tape: <input type="checkbox"/> x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> See Flow Sheet 60 min <input type="checkbox"/>	Kinesio tape: <input type="checkbox"/> x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> Leuko tape: <input type="checkbox"/> x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> x 3 <input type="checkbox"/> THERAPEUTIC EXERCISES: 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> See Flow Sheet 60 min <input type="checkbox"/>	
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MHACP	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> OTHER:	To: C/S <input type="checkbox"/> Shoulders <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back <input type="checkbox"/> R UEO <input type="checkbox"/> L UEO <input type="checkbox"/> R LEO <input type="checkbox"/> L LEO <input type="checkbox"/> Hand <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> TIME: 20 min <input type="checkbox"/> OTHER:	
Assessment	<i>Re measure for symmetry ③ To Body</i>		
Plan	<i>Hold on to</i> <i>SGR 7/22/15</i>		

07/17/2012 13:19 FAX

4004

NAME: _____
DATE: _____

SSN: DATE:

Mr. Brown stated she
had no 4/18 since last
RK

No 1 in works to try them
to paragons

To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UEO□
L UEO□ R LEO□ L LEO□ Hand□ Elbow□ Wrist□ Knee□
Ankle□ TIME: 10 min □ 15 min □ 20 min □ 25 min □
OTHER:

To Musculature of: C/S Shoulders Mid Back Hip
Low Back R.UEO L.UEO R.LEO L.LEO Hand
Wrist Elbow Knee Ankle
TIME: 20 min 25 min 30 min 88
OTHER:

Kinesio tape: x 1 x 2 x 3
Louko tape: x 1 x 2 x 3
THERAPEUTIC EXERCISES: 15 min 30 min 45 min
See Flow Sheet 60 min

To: C/SO Shoulders Mid Back Low Back Hip
R UEO L UEO R LEO L LEO Hand Elbow Wrist Knee
Ankle Dexamethasone Acetic Acid
x1 treatment x 2 treatments x 24 minutes

To: C/S[□] Shoulders[□] Mid Back[□] Low Back[□] Hip[□] R. UE[□]
L. UE[□] R. LE[□] L. LE[□] Hand[□] Elbow[□] Wrist[□] Knee[□]
Ankle[□] TIME: 10 min[□] 15 min[□] 20 min[□] 25 min[□]
W/CM2: .5[□] 1.0[□] 1.5[□] 2.0[□] 2.5[□]

To: C/S Shoulders Mid Back Low Back Hip R U/B L U/B R L/E L L/E Hand Elbow Wrist Knee Ankle
TIME: 15 min 20 min 25 min 30 min
OTHER:

To: C/S Shoulder Mid Back Low Back Hip R UEO
 L UEO R LEO L RÉ Hand Elbow Wrist Knee Knee Ankle
TIME: 30 min 45 min
OTHER:

To: C/S Shoulders Mid Back Low Back Hip
R UEO L UEO R LEO L LEO Hand Elbow Wrist
Knee Ankle TIME: 20 min
OTHER:

But take my word for it
no c/o & all persons
lost &

Cont'd on next page

Kevin J. Seroi, RPT

58

07/17/2012 13:20 FAX

10000

Subjective	SSN: DATE: 6-9-09 ✓	
	Pt. Drol. stated [REDACTED] has not had a HT since last 2	
Objective	Pt not as fatigued Today	
NERVO & ES	To: C/S [□] Shoulders [□] Mid Back [□] Low Back [□] Hip [□] R UE [□] L UEO [□] R LEO [□] L LEO [□] Hand [□] Elbow [□] Wrist [□] Knee [□] Ankle [□] TIME: 10 min [□] 15 min [□] 20 min [□] 25 min [□] OTHER:	To: C/S [□] Shoulders [□] Mid Back [□] Low Back [□] Hip [□] R UE [□] L UEO [□] R LEO [□] L LEO [□] Hand [□] Elbow [□] Wrist [□] Knee [□] Ankle [□] TIME: 10 min [□] 15 min [□] 20 min [□] 25 min [□] OTHER:
Massage	To Musculature of: C/S [□] Shoulders [□] Mid Back [□] Hip [□] Low Back [□] R UEO [□] L UEO [□] R LEO [□] L LEO [□] Hand [□] Wrist [□] Elbow [□] Knee [□] Ankle [□] TIME: 20 min [□] 25 min [□] 30 min [□] OTHER:	To Musculature of: C/S [□] Shoulders [□] Mid Back [□] Hip [□] Low Back [□] R UEO [□] L UEO [□] R LEO [□] L LEO [□] Hand [□] Wrist [□] Elbow [□] Knee [□] Ankle [□] TIME: 20 min [□] 25 min [□] 30 min [□] OTHER:
Tape/TE	Kinesio tape: x 1 [□] x 2 [□] x 3 [□] Louko tape: x 1 [□] x 2 [□] x 3 [□] THERAPEUTIC EXERCISES: 15 min [□] 30 min [□] 45 min [□] See Flow Sheet 60 min [□]	Kinesio tape: x 1 [□] x 2 [□] x 3 [□] Louko tape: x 1 [□] x 2 [□] x 3 [□] THERAPEUTIC EXERCISES: 15 min [□] 30 min [□] 45 min [□] See Flow Sheet 60 min [□]
Ionto	To: C/S [□] Shoulders [□] Mid Back [□] Low Back [□] Hip [□] R UEO [□] L UEO [□] R LEO [□] L LEO [□] Hand [□] Elbow [□] Wrist [□] Knee [□] Ankle [□] Dexamethasone [□] Acetic Acid [□] x 1 treatment [□] x 2 treatments [□] x 24 minutes [□]	To: C/S [□] Shoulders [□] Mid Back [□] Low Back [□] Hip [□] R UEO [□] L UEO [□] R LEO [□] L LEO [□] Hand [□] Elbow [□] Wrist [□] Knee [□] Ankle [□] Dexamethasone [□] Acetic Acid [□] x 1 treatment [□] x 2 treatments [□] x 24 minutes [□]
US	To: C/S [□] Shoulders [□] Mid Back [□] Low Back [□] Hip [□] R UEO [□] L UEO [□] R LEO [□] L LEO [□] Hand [□] Elbow [□] Wrist [□] Knee [□] Ankle [□] TIME: 10 min [□] 15 min [□] 20 min [□] 25 min [□] W/CM2: .50 1.00 1.50 2.00 2.50	To: C/S [□] Shoulders [□] Mid Back [□] Low Back [□] Hip [□] R UEO [□] R LEO [□] L LEO [□] Hand [□] Elbow [□] Wrist [□] Knee [□] Ankle [□] TIME: 10 min [□] 15 min [□] 20 min [□] 25 min [□] W/CM2: .50 1.00 1.50 2.00 2.50
Mammary	To: C/S [□] Shoulders [□] Mid Back [□] Low Back [□] Hip [□] R UEO [□] L UEO [□] R LEO [□] L LEO [□] Hand [□] Elbow [□] Wrist [□] Knee [□] Ankle [□] TIME: 15 min [□] 20 min [□] 25 min [□] 30 min [□] OTHER:	To: C/S [□] Shoulders [□] Mid Back [□] Low Back [□] Hip [□] R UEO [□] R LEO [□] L LEO [□] Hand [□] Elbow [□] Wrist [□] Knee [□] Ankle [□] TIME: 15 min [□] 20 min [□] 25 min [□] 30 min [□] OTHER:
Anodysm	To: C/S [□] Shoulders [□] Mid Back [□] Low Back [□] Hip [□] R UEO [□] L UEO [□] R LEO [□] L LEO [□] Hand [□] Elbow [□] Wrist [□] Knee [□] Ankle [□] TIME: 30 min [□] 45 min [□] OTHER:	To: C/S [□] Shoulders [□] Mid Back [□] Low Back [□] Hip [□] R UEO [□] R LEO [□] L LEO [□] Hand [□] Elbow [□] Wrist [□] Knee [□] Ankle [□] TIME: 30 min [□] 45 min [□] OTHER:
MH/CP	To: C/S [□] Shoulders [□] Mid Back [□] Low Back [□] Hip [□] R UEO [□] L UEO [□] R LEO [□] L LEO [□] Hand [□] Elbow [□] Wrist [□] Knee [□] Ankle [□] TIME: 20 min [□] OTHER:	To: C/S [□] Shoulders [□] Mid Back [□] Low Back [□] Hip [□] R UEO [□] L UEO [□] R LEO [□] L LEO [□] Hand [□] Elbow [□] Wrist [□] Knee [□] Ankle [□] TIME: 20 min [□] OTHER:
Assessment	Pt. stat R well had no C10 pain to R	Pt. stat R well had no C10 pain to R
Plan	Cont to current plan X Myosot, PT	Cont to current plan X Myosot, PT

07/17/2012 13:20 FAX

006

NAME: [REDACTED]
DATE: 5/14/09SSN: [REDACTED]
DATE: 6/2/09

Subjective

PT mom stated [REDACTED]
was playing for 2-3 Hrs
Then No more HT

PT's dad stated her
wife have had since
not having PT

Objective

No signs & no muscle
Tension to back

PT very fatigued
Tired

NEURO
Re-EA

To: C/S Shoulders Mid Back Low Back Hip R UEO L UEO R LEO L LEO Hand Elbow Wrist Knee Ankle TIME: 10 min 15 min 20 min 25 min OTHER:

To: C/S Shoulders Mid Back Low Back Hip R UEO L UEO R LEO L LEO Hand Elbow Wrist Knee Ankle TIME: 10 min 15 min 20 min 25 min OTHER:

Massage

To Musculature of: C/S Shoulders Mid Back Hip Low Back R UEO L UEO R LEO L LEO Hand Wrist Elbow Knee Ankle TIME: 20 min 25 min 30 min OTHER:

To Musculature of: C/S Shoulders Mid Back Hip Low Back R UEO L UEO R LEO L LEO Hand Wrist Elbow Knee Ankle TIME: 20 min 25 min 30 min OTHER: *FB* *PERFORMS*

Tape/TE

Kinesio tape: x 1 x 2 x 3
Leuko tape: x 1 x 2 x 3
THERAPEUTIC EXERCISES: 15 min 30 min 45 min
See Flow Sheet 60 min

Kinesio tape: x 1 x 2 x 3
Leuko tape: x 1 x 2 x 3
THERAPEUTIC EXERCISES: 15 min 30 min 45 min
See Flow Sheet 60 min

Ionto

To: C/S Shoulders Mid Back Low Back Hip R UEO L UEO R LEO L LEO Hand Elbow Wrist Knee Ankle Doxamethasone Acetic Acid
x1 treatment x 2 treatments x 24 minutes

To: C/S Shoulders Mid Back Low Back Hip R UEO L UEO R LEO L LEO Hand Elbow Wrist Knee Ankle Doxamethasone Acetic Acid
x1 treatment x 2 treatments x 24 minutes

US

To: C/S Shoulders Mid Back Low Back Hip R UEO L UEO R LEO L LEO Hand Elbow Wrist Knee Ankle TIME: 10 min 15 min 20 min 25 min
W/CM2: .5 1.0 1.5 2.0 2.5

To: C/S Shoulders Mid Back Low Back Hip L UEO R LEO L LEO Hand Elbow Wrist Knee Ankle TIME: 10 min 15 min 20 min 25 min
W/CM2: .5 1.0 1.5 2.0 2.5

Manual

To: C/S Shoulders Mid Back Low Back Hip R UEO L UEO R LEO L LEO Hand Elbow Wrist Knee Ankle TIME: 15 min 20 min 25 min 30 min OTHER:

To: C/S Shoulders Mid Back Low Back Hip L UEO R LEO L LEO Hand Elbow Wrist Knee Ankle TIME: 15 min 20 min 25 min 30 min OTHER:

Anodyne

To: C/S Shoulders Mid Back Low Back Hip R UEO L UEO R LEO L LEO Hand Elbow Wrist Knee Ankle TIME: 30 min 45 min OTHER:

To: C/S Shoulders Mid Back Low Back Hip L UEO R LEO L LEO Hand Elbow Wrist Knee Ankle TIME: 30 min 45 min OTHER:

ME/CP

To: C/S Shoulders Mid Back Low Back Hip R UEO L UEO R LEO L LEO Hand Elbow Wrist Knee Ankle TIME: 20 min OTHER:

To: C/S Shoulders Mid Back Low Back Hip R UEO L UEO R LEO L LEO Hand Elbow Wrist Knee Ankle TIME: 20 min OTHER:

Assessment

PT mom stated
no cr/o HT & R

PT dad reported
well back no
cr/o HT & R

Plan

Con't & current PT
X *Signs of* *PT*

Con't & current PT
X *Signs of* *PT*

07/17/2012 13:21 FAX

007

NAME:
DATE:

5/17/09

SSN:
DATE:

5/12/09

Subjective

Pt stated she was
Tired Today

Pt mother stated
has not had
any HA since last

Objective

Pt to have Photo Taken
Today

No t = muscle tension
to back

NEURO
Re-Eval

To: C/S[□] Shoulders[□] Mid Back[□] Low Back[□] Hip[□] R UEO[□]
L UEO[□] R LEO[□] L LEO[□] Hand[□] Elbow[□] Wrist[□] Knee[□]
Ankle[□] TIME: 10 min[□] 15 min[□] 20 min[□] 25 min[□]
OTHER:

To: C/S[□] Shoulders[□] Mid Back[□] Low Back[□] Hip[□] R
L UEO[□] R LEO[□] L LEO[□] Hand[□] Elbow[□] Wrist[□] Knee[□]
Ankle[□] TIME: 10 min[□] 15 min[□] 20 min[□] 25 min[□]
OTHER:

Massage

To Musculature of: C/S[□] Shoulders[□] Mid Back[□] Hip[□]
Low Back[□] R UEO[□] L UEO[□] R LEO[□] L LEO[□] Hand[□]
Wrist[□] Elbow[□] Knee[□] Ankle[□]
TIME: 20 min[□] 25 min[□] 30 min[□]
OTHER:

To Musculature of: C/S[□] Shoulders[□] Mid Back[□] Hip[□]
Low Back[□] R UEO[□] L UEO[□] R LEO[□] L LEO[□] Hand[□]
Wrist[□] Elbow[□] Knee[□] Ankle[□]
TIME: 20 min[□] 25 min[□] 30 min[□]
OTHER: Glutes, ITB, Piriformis

Tape/TIE

Kinesio tape: x 1[□] x 2[□] x 3[□]
Leuko tape: x 1[□] x 2[□] x 3[□]
THERAPEUTIC EXERCISES: 15 min[□] 30 min[□] 45 min[□]
See Flow Sheet 60 min[□]

Kinesio tape: x 1[□] x 2[□] x 3[□]
Leuko tape: x 1[□] x 2[□] x 3[□]
THERAPEUTIC EXERCISES: 15 min[□] 30 min[□] 45 min[□]
See Flow Sheet 60 min[□]

Ionto

To: C/S[□] Shoulders[□] Mid Back[□] Low Back[□] Hip[□]
R UEO[□] L UEO[□] R LEO[□] L LEO[□] Hand[□] Elbow[□] Wrist[□] Knee[□]
Ankle[□] Dexamethasone[□] Acetic Acid[□]
x1 treatment[□] x 2 treatments[□] x 24 minutes[□]

To: C/S[□] Shoulders[□] Mid Back[□] Low Back[□] Hip[□]
R UEO[□] L UEO[□] R LEO[□] L LEO[□] Hand[□] Elbow[□] Wrist[□]
Ankle[□] Dexamethasone[□] Acetic Acid[□]
x1 treatment[□] x 2 treatments[□] x 24 minutes[□]

US

To: C/S[□] Shoulders[□] Mid Back[□] Low Back[□] Hip[□] R UEO[□]
L UEO[□] R LEO[□] L LEO[□] Hand[□] Elbow[□] Wrist[□] Knee[□]
Ankle[□] TIME: 10 min[□] 15 min[□] 20 min[□] 25 min[□]
W/CM2: .5[□] 1.0[□] 1.5[□] 2.0[□] 2.5[□]

To: C/S[□] Shoulders[□] Mid Back[□] Low Back[□] Hip[□]
L UEO[□] R LEO[□] L LEO[□] Hand[□] Elbow[□] Wrist[□] Knee[□]
Ankle[□] TIME: 10 min[□] 15 min[□] 20 min[□] 25 min[□]
W/CM2: .5[□] 1.0[□] 1.5[□] 2.0[□] 2.5[□]

Mammary

To: C/S[□] Shoulders[□] Mid Back[□] Low Back[□] Hip[□] R UEO[□]
L UEO[□] R LEO[□] L LEO[□] Hand[□] Elbow[□] Wrist[□] Knee[□]
Ankle[□] TIME: 15 min[□] 20 min[□] 25 min[□] 30 min[□]
OTHER:

To: C/S[□] Shoulders[□] Mid Back[□] Low Back[□] Hip[□]
L UEO[□] R LEO[□] L LEO[□] Hand[□] Elbow[□] Wrist[□] Knee[□]
TIME: 15 min[□] 20 min[□] 25 min[□] 30 min[□]
OTHER:

Anodyne

To: C/S[□] Shoulders[□] Mid Back[□] Low Back[□] Hip[□] R UEO[□]
L UEO[□] R LEO[□] L LEO[□] Hand[□] Elbow[□] Wrist[□] Knee[□]
Ankle[□] TIME: 30 min[□] 45 min[□]
OTHER:

To: C/S[□] Shoulders[□] Mid Back[□] Low Back[□] Hip[□]
L UEO[□] R LEO[□] L LEO[□] Hand[□] Elbow[□] Wrist[□] Knee[□]
TIME: 30 min[□] 45 min[□]
OTHER:

ME/CP

To: C/S[□] Shoulders[□] Mid Back[□] Low Back[□] Hip[□]
R UEO[□] L UEO[□] R LEO[□] L LEO[□] Hand[□] Elbow[□] Wrist[□]
Knee[□] Ankle[□] TIME: 20 min[□]
OTHER:

To: C/S[□] Shoulders[□] Mid Back[□] Low Back[□] Hip[□]
R UEO[□] L UEO[□] R LEO[□] L LEO[□] Hand[□] Elbow[□] Wrist[□]
Knee[□] Ankle[□] TIME: 20 min[□]
OTHER:

Assessment

Pt still remains a
little tired to be

Pt still remains a
little tired to be

Plan

Cont to current doc
Sgrol, RPT

Cont to current doc
Sgrol, RPT

07/17/2012 10:22 FAX

008

NAME	SS	
DATE: 5/5/09	DATE: 5/5/09 ✓	
Subjective	Re: pt from stated her Suffered no drainage to much esp	
Objective	No + - muscle tension low back mid back	
NEURO R-Ed	To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UEO L UEO R LEO L LEO Hand□ Elbow□ Wrist□ Knee□ Ankle□ TIME: 10 min □ 15 min □ 20 min □ 25 min □ OTHER:	To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ L UEO R LEO L LEO Hand□ Elbow□ Wrist□ X Ankle□ TIME: 10 min □ 15 min □ 20 min □ OTHER
Massage	To Musculature of: C/S□ Shoulders□ Mid Back□ Hip□ Low Back□ R UEO L UEO R LEO L LEO Hand□ Wrist□ Elbow□ Knee□ Ankle□ TIME: 20 min □ 25 min □ 30 min □ OTHER: ITB & Piriformis	To Musculature of: C/S□ Shoulders□ Mid Back□ X Low Back□ R UEO L UEO R LEO L LEO H Wrist□ Elbow□ Knee□ Ankle□ TIME: 20 min □ 25 min □ 30 min □ OTHER: ITB & Glutes
Tape/TE	Kinesio tape: x 1 □ x 2 □ x 3 □ Leuko tape: x 1 □ x 2 □ x 3 □ THERAPEUTIC EXERCISES: 15 min □ 30 min □ 45 min □ See Flow Sheet 60 min □	Kinesio tape: x 1 □ x 2 □ x 3 □ Leuko tape: x 1 □ x 2 □ x 3 □ THERAPEUTIC EXERCISES: 15 min □ 30 min □ 45 See Flow Sheet 60 min □
Joint	To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UEO L UEO R LEO L LEO Hand□ Elbow□ Wrist□ Knee□ Ankle□ Dexamethasone □ Acetic Acid □ x1 treatment □ x 2 treatments □ x 24 minutes □	To: C/S□ Shoulders□ Mid Back□ Low Back□ I R UEO L UEO R LEO L LEO Hand□ Elbow□ Wrist Ankle□ Dexamethasone □ Acetic Acid □ x1 treatment □ x 2 treatments □ x 24 minutes □
US	To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UEO L UEO R LEO L LEO Hand□ Elbow□ Wrist□ Knee□ Ankle□ TIME: 10 min □ 15 min □ 20 min □ 25 min □ W/CM2: .50 1.00 1.50 2.00 2.50	To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ L UEO R LEO L LEO Hand□ Elbow□ Wrist□ X Ankle□ TIME: 10 min □ 15 min □ 20 min □ W/CM2: .50 1.00 1.50 2.00 2.50
Muscul	To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UEO L UEO R LEO L LEO Hand□ Elbow□ Wrist□ Knee□ Ankle□ TIME: 15 min □ 20 min □ 25 min □ 30 min □ OTHER:	To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ L UEO R LEO L LEO Hand□ Elbow□ Wrist□ Knee□ TIME: 15 min □ 20 min □ 25 min □ 30 min □ OTHER:
Anatomy	To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UEO L UEO R LEO L LEO Hand□ Elbow□ Wrist□ Knee□ Ankle□ TIME: 30 min □ 45 min □ OTHER:	To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ L UEO R LEO L LEO Hand□ Elbow□ Wrist□ Knee□ TIME: 30 min □ 45 min □ OTHER:
Muscp	To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UEO L UEO R LEO L LEO Hand□ Elbow□ Wrist□ Knee□ Ankle□ TIME: 20 min □ OTHER:	To: C/S□ Shoulders□ Mid Back□ Low Back□ X R UEO L UEO R LEO L LEO Hand□ Elbow□ Knee□ Ankle□ TIME: 20 min □ OTHER:
Assessment	pt had R small red no c/o pain p/r	pt had R small red had no c/o 1/4 to R
Plan	cont c current pt D. Sgroi PT	cont c current pt D. Sgroi PT

Kevin J. Sgroi, RPT

Kevin J. Sgroi, RPT

07/17/2012 13:22 FAX

40009

Subjective

NAME
DATE: 7/23/09SSN:
DATE: 4/28/69 ✓

Objective

Re: Mom stated
has been sick for
few wks

NO signif + no muscle
Tension to back

Re: stated she does
not have as many
p/A

No + in muscle tension
to back

NEURO
P/E

To: C/S Shoulders Mid Back Low Back Hip R UEO
L UEO R LEO L LEO Hand Elbow Wrist Knee Ankle
TIME: 10 min 15 min 20 min 25 min
OTHER:

To: C/S Shoulders Mid Back Low Back Hip R UEO
L UEO R LEO L LEO Hand Elbow Wrist Knee Ankle
TIME: 10 min 15 min 20 min 25 min
OTHER:

Massage

To Musculature of: C/S Shoulders Mid Back Hip
Low Back R UEO L UEO R LEO L LEO Hand
Wrist Elbow Knee Ankle
TIME: 20 min 25 min 30 min
OTHER: Gloves, ITB, PRTOCHL8

To Musculature of: C/S Shoulders Mid Back Hip
Low Back R UEO L UEO R LEO L LEO Hand
Wrist Elbow Knee Ankle
TIME: 20 min 25 min 30 min
OTHER:

Tape/TE

Kinesio tape: x 1 x 2 x 3
Leuko tape: x 1 x 2 x 3
THERAPEUTIC EXERCISES: 15 min 30 min 45 min
See Flow Sheet 60 min

Kinesio tape: x 1 x 2 x 3
Leuko tape: x 1 x 2 x 3
THERAPEUTIC EXERCISES: 15 min 30 min 45 min
See Flow Sheet 60 min

Joint

To: C/S Shoulders Mid Back Low Back Hip
R UEO L UEO R LEO L LEO Hand Elbow Wrist Knee
Ankle Dexamethasone Acetic Acid
x 1 treatment x 2 treatments x 24 minutes

To: C/S Shoulders Mid Back Low Back Hip
R UEO L UEO R LEO L LEO Hand Elbow Wrist Knee
Ankle Dexamethasone Acetic Acid
x 1 treatment x 2 treatments x 24 minutes

IS

To: C/S Shoulders Mid Back Low Back Hip R UEO
L UEO R LEO L LEO Hand Elbow Wrist Knee Ankle
TIME: 10 min 15 min 20 min 25 min
W/CM2: .50 1.00 1.50 2.00 2.50

To: C/S Shoulders Mid Back Low Back Hip R UEO
L UEO R LEO L LEO Hand Elbow Wrist Knee Ankle
TIME: 10 min 15 min 20 min 25 min
W/CM2: .50 1.00 1.50 2.00 2.50

Manual

To: C/S Shoulders Mid Back Low Back Hip R UEO
L UEO R LEO L LEO Hand Elbow Wrist Knee Ankle
TIME: 15 min 20 min 25 min 30 min
OTHER:

To: C/S Shoulders Mid Back Low Back Hip R UEO
L UEO R LEO L LEO Hand Elbow Wrist Knee Ankle
TIME: 15 min 20 min 25 min 30 min
OTHER:

Analgene

To: C/S Shoulders Mid Back Low Back Hip R UEO
L UEO R LEO L LEO Hand Elbow Wrist Knee Ankle
TIME: 30 min 45 min
OTHER:

To: C/S Shoulders Mid Back Low Back Hip R UEO
L UEO R LEO L LEO Hand Elbow Wrist Knee Ankle
TIME: 30 min 45 min
OTHER:

M/HCP

To: C/S Shoulders Mid Back Low Back Hip
R UEO L UEO R LEO L LEO Hand Elbow Wrist
Knee Ankle
TIME: 20 min
OTHER:

To: C/S Shoulders Mid Back Low Back Hip R UEO
L UEO R LEO L LEO Hand Elbow Wrist Knee Ankle
TIME: 20 min
OTHER:

Plan

Re: still recall had
no c/o pain to the

Re: still recall had
no c/o pain to the

Cont'd current doc

Cont'd current doc

07/17/2012 13:23 FAX

010

NAME:
DATE:

3/24/09

SSN:
DATE:

3/26/09

Subjective

Objective

NEURO
Re-Fx

Massage

Tape/TE

Ionto

US

Manual

Anodyne

MHCP

Assessment

Plan

Pt mother stated [REDACTED]
did not have HT for
4-5 days

Pt has been no
HT since last

No r/t muscle tension
c/s / Osfield

Never r/t muscle
Tension to back

To: C/S[□] Shoulders[□] Mid Back[□] Low Back[□] Hip[□] R UEO[□]
L UEO[□] R LEO[□] L LEO[□] Hand[□] Elbow[□] Wrist[□] Knee[□]
Ankle[□] TIME: 10 min[□] 15 min[□] 20 min[□] 25 min[□]
OTHER:

To: C/S[□] Shoulders[□] Mid Back[□] Low Back[□] Hip[□] R UEO[□]
L UEO[□] R LEO[□] L LEO[□] Hand[□] Elbow[□] Wrist[□] Knee[□]
Ankle[□] TIME: 10 min[□] 15 min[□] 20 min[□] 25 min[□]
OTHER:

To Musculature of: C/S[□] Shoulders[□] Mid Back[□] Hip[□]
Low Back[□] R UEO[□] L UEO[□] R LEO[□] L LEO[□] Hand[□]
Wrist[□] Elbow[□] Knee[□] Ankle[□]
TIME: 20 min[□] 25 min[□] 30 min[□]
OTHER:

To Musculature of: C/S[□] Shoulders[□] Mid Back[□] Hip[□]
Low Back[□] R UEO[□] L UEO[□] R LEO[□] L LEO[□] Hand[□]
Wrist[□] Elbow[□] Knee[□] Ankle[□]
TIME: 20 min[□] 25 min[□] 30 min[□]
OTHER:

Kinesio tape: x 1[□] x 2[□] x 3[□]
Leuko tape: x 1[□] x 2[□] x 3[□]

Kinesio tape: x 1[□] x 2[□] x 3[□]
Leuko tape: x 1[□] x 2[□] x 3[□]

THERAPEUTIC EXERCISES: 15 min[□] 30 min[□] 45 min[□]
See Flow Sheet 60 min[□]

THERAPEUTIC EXERCISES: 15 min[□] 30 min[□] 45 min[□]
See Flow Sheet 60 min[□]

To: C/S[□] Shoulders[□] Mid Back[□] Low Back[□] Hip[□]
R UEO[□] L UEO[□] R LEO[□] L LEO[□] Hand[□] Elbow[□] Wrist[□] Knee[□]
Ankle[□] Doxamethasone[□] Acetic Acid[□]
x1 treatment[□] x 2 treatments[□] x 24 minutes[□]

To: C/S[□] Shoulders[□] Mid Back[□] Low Back[□] Hip[□]
R UEO[□] L UEO[□] R LEO[□] L LEO[□] Hand[□] Elbow[□] Wrist[□] Knee[□]
Ankle[□] Doxamethasone[□] Acetic Acid[□]
x1 treatment[□] x 2 treatments[□] x 24 minutes[□]

To: C/S[□] Shoulders[□] Mid Back[□] Low Back[□] Hip[□] R UEO[□]
L UEO[□] R LEO[□] L LEO[□] Hand[□] Elbow[□] Wrist[□] Knee[□]
Ankle[□] TIME: 10 min[□] 15 min[□] 20 min[□] 25 min[□]
W/CM2: .5[□] 1.0[□] 1.5[□] 2.0[□] 2.5[□]

To: C/S[□] Shoulders[□] Mid Back[□] Low Back[□] Hip[□] R UEO[□]
L UEO[□] R LEO[□] L LEO[□] Hand[□] Elbow[□] Wrist[□] Knee[□]
Ankle[□] TIME: 10 min[□] 15 min[□] 20 min[□] 25 min[□]
W/CM2: .5[□] 1.0[□] 1.5[□] 2.0[□] 2.5[□]

To: C/S[□] Shoulders[□] Mid Back[□] Low Back[□] Hip[□] R UEO[□]
L UEO[□] R LEO[□] L LEO[□] Hand[□] Elbow[□] Wrist[□] Knee[□] Ankle[□]
TIME: 15 min[□] 20 min[□] 25 min[□] 30 min[□]
OTHER:

To: C/S[□] Shoulders[□] Mid Back[□] Low Back[□] Hip[□] R UEO[□]
L UEO[□] R LEO[□] L LEO[□] Hand[□] Elbow[□] Wrist[□] Knee[□] Ankle[□]
TIME: 15 min[□] 20 min[□] 25 min[□] 30 min[□]
OTHER:

To: C/S[□] Shoulders[□] Mid Back[□] Low Back[□] Hip[□] R UEO[□]
L UEO[□] R LEO[□] L LEO[□] Hand[□] Elbow[□] Wrist[□] Knee[□] Ankle[□]
TIME: 30 min[□] 45 min[□]
OTHER:

To: C/S[□] Shoulders[□] Mid Back[□] Low Back[□] Hip[□] R UEO[□]
L UEO[□] R LEO[□] L LEO[□] Hand[□] Elbow[□] Wrist[□] Knee[□] Ankle[□]
TIME: 30 min[□] 45 min[□]
OTHER:

To: C/S[□] Shoulders[□] Mid Back[□] Low Back[□] Hip[□] R UEO[□]
L UEO[□] R LEO[□] L LEO[□] Hand[□] Elbow[□] Wrist[□] Knee[□] Ankle[□]
TIME: 20 min[□]
OTHER:

To: C/S[□] Shoulders[□] Mid Back[□] Low Back[□] Hip[□] R UEO[□]
L UEO[□] R LEO[□] L LEO[□] Hand[□] Elbow[□] Wrist[□] Knee[□] Ankle[□]
TIME: 20 min[□]
OTHER:

Pt tol well to no
c/o HT pain to the

Pt tol well to no
c/o pain to the

cont'd current doc

cont'd current doc

07/17/2012 13:24 FAX

4011

Subjective

NAME
DATE: 3/16/09SSN:
DATE: 3/19/09SEE
TEPt has stated
had a HT for ~ 2 days
to start no NO side effects
HT starting

Objective

SEE
TENo signif st
mucle tensionNEURO
Re-EdTo: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UED□
L UED□ R LED□ L LED□ Hand□ Elbow□ Wrist□ Knee□
Ankle□ TIME: 10 min□ 15 min□ 20 min□ 25 min□
OTHER:To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□
L UED□ R LED□ L LED□ Hand□ Elbow□ Wrist□
Ankle□ TIME: 10 min□ 15 min□ 20 min□
OTHER:

Massage

To Musculature of: C/S□ Shoulders□ Mid Back□ Hip□
Low Back□ R UED□ L UED□ R LED□ L LED□ Hand□
Wrist□ Elbow□ Knee□ Ankle□
TIME: 20 min□ 25 min□ 30 min□
OTHER:To Musculature of: C/S□ Shoulders□ Mid Back□
Low Back□ R UED□ L UED□ R LED□ L LED□
Wrist□ Elbow□ Knee□ Ankle□ HIPS
TIME: 20 min□ 25 min□ 30 min□
OTHER:

Tape/TE

Kinesio tape: x 1□ x 2□ x 3□
Leuko tape: x 1□ x 2□ x 3□
THERAPEUTIC EXERCISES: 15 min□ 30 min□ 45 min□
See Flow Sheet 60 min□Kinesio tape: x 1□ x 2□ x 3□
Leuko tape: x 1□ x 2□ x 3□
THERAPEUTIC EXERCISES: 15 min□ 30 min□ 45 min□
See Flow Sheet 60 min□

Iont

To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□
R UED□ L UED□ R LED□ L LED□ Hand□ Elbow□ Wrist□
Ankle□ Dexamethasone □ Acetic Acid □
x1 treatment□ x 2 treatments□ x 24 minutes□To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□
R UED□ L UED□ R LED□ L LED□ Hand□ Elbow□ Wrist□
Ankle□ Dexamethasone □ Acetic Acid □
x1 treatment□ x 2 treatments□ x 24 minutes□

US

To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UED□
L UED□ R LED□ L LED□ Hand□ Elbow□ Wrist□ Knee□
Ankle□ TIME: 10 min□ 15 min□ 20 min□ 25 min□
W/CM2: .50 1.0□ 1.50 2.0□ 2.5□To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□
L UED□ R LED□ L LED□ Hand□ Elbow□ Wrist□
Ankle□ TIME: 10 min□ 15 min□ 20 min□
W/CM2: .50 1.0□ 1.50 2.0□ 2.5□

Manual

To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UED□
L UED□ R LED□ L LED□ Hand□ Elbow□ Wrist□ Knee□ Ankle□
TIME: 15 min□ 20 min□ 25 min□ 30 min□
OTHER:To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□
L UED□ R LED□ L LED□ Hand□ Elbow□ Wrist□
TIME: 15 min□ 20 min□ 25 min□ 30 min□
OTHER:

Anodyne

To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UED□
L UED□ R LED□ L LED□ Hand□ Elbow□ Wrist□ Knee□ Ankle□
TIME: 30 min□ 45 min□
OTHER:To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□
L UED□ R LED□ L LED□ Hand□ Elbow□ Wrist□
TIME: 30 min□ 45 min□
OTHER:

MH/CP

To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□ R UED□
L UED□ R LED□ L LED□ Hand□ Elbow□ Wrist□
Knee□ Ankle□ TIME: 20 min□
OTHER:To: C/S□ Shoulders□ Mid Back□ Low Back□ Hip□
R UED□ L UED□ R LED□ L LED□ Hand□ Elbow□
Knee□ Ankle□ TIME: 20 min□
OTHER:

Plan

Pt at time dictated
no c/o HT to PPt total normal
had no c/o pain
P/ECont & current P/E
J. Sgrol, RPTCont & current P/E
J. Sgrol, RPT

Kevin J. Sgrol, RPT

Kevin J. Sgrol, RPT

NAME:	5/10/11	DATE:	5/10/11
REFERRING PHYSICIAN:			
DISCIPLINE:	Physical therapy		
DISCIPLINE:	Physical therapy		
NEURO:	Mod muscle Tension to low back		
NEURO: 2EED	TO: C/S D SHOULDER(S) MID BACK(L) LOW BACK(R) HIP(R) UEB(L) UEB(R) LLE(L) RLE(R) HAN(L) WRIST(L) ELBOW(L) KNEE(L) ANKLE(L) FOOT(L) TIME: 10 MIN(L) 15 MIN(R) 20 MIN(L) 25 MIN(R) 30 MIN(R) OTHER:		
NEURO: 2EED	TO: C/S D SHOULDER(S) MID BACK(L) LOW BACK(R) HIP(R) UEB(L) UEB(R) LLE(L) RLE(R) HAN(L) WRIST(L) ELBOW(L) KNEE(L) ANKLE(L) FOOT(L) TIME: 10 MIN(L) 15 MIN(R) 20 MIN(L) 25 MIN(R) 30 MIN(R) OTHER:		
MUSCLES:	TO MUSCULATURE OF: C/S D SHOULDER(S) MID BACK(L) LOW BACK(R) HIP(R) UEB(L) UEB(R) LLE(L) RLE(R) HAN(L) WRIST(L) ELBOW(L) KNEE(L) ANKLE(L) FOOT(L) TIME: 20 MIN(L) 25 MIN(R) 30 MIN(L) 40 MIN(R) OTHER:		
MUSCLES:	TO MUSCULATURE OF: C/S D SHOULDER(S) MID BACK(L) LOW BACK(R) HIP(R) UEB(L) UEB(R) LLE(L) RLE(R) HAN(L) WRIST(L) ELBOW(L) KNEE(L) ANKLE(L) FOOT(L) TIME: 20 MIN(L) 25 MIN(R) 30 MIN(L) 40 MIN(R) OTHER:		
LEAVE:	KINESIO TAPE: X10 x2in x3in LEUKO TAPE: X10 x2in x3in THERAPEUTIC EXERCISES: 15 MIN(L) 30 MIN(R) 45 MIN(L) 60 MIN(R) SEE FLOW SHEET		
LEAVE:	KINESIO TAPE: X10 x2in x3in LEUKO TAPE: X10 x2in x3in THERAPEUTIC EXERCISES: 15 MIN(L) 30 MIN(R) 45 MIN(L) 60 MIN(R) SEE FLOW SHEET		
TOPIC:	TO: C/S D SHOULDER(S) MID BACK(L) LOW BACK(R) HIP(R) UEB(L) UEB(R) LLE(L) RLE(R) HAN(L) WRIST(L) ELBOW(L) KNEE(L) ANKLE(L) FOOT(L) DEXAMETHASONE(D) >1 TREATMENT(L) >2 TREATMENTS(R) <24 MINUTES(L) ACETIC ACID(D) >1 TREATMENT(L) >2 TREATMENTS(R) <24 MINUTES(L)		
TOPIC:	TO: C/S D SHOULDER(S) MID BACK(L) LOW BACK(R) HIP(R) UEB(L) UEB(R) LLE(L) RLE(R) HAN(L) WRIST(L) ELBOW(L) KNEE(L) ANKLE(L) FOOT(L) TIME: 10 MIN(L) 15 MIN(R) 20 MIN(L) 25 MIN(R) W/CM2: 3.0 1.0 1.5 1.2 0.0 2.0 2.5 1.0		
ADVISOR:	TO: C/S D SHOULDER(S) MID BACK(L) LOW BACK(R) HIP(R) UEB(L) UEB(R) LLE(L) RLE(R) HAN(L) WRIST(L) ELBOW(L) KNEE(L) ANKLE(L) FOOT(L) TIME: 10 MIN(L) 15 MIN(R) 20 MIN(L) 25 MIN(R) OTHER:		
ADVISOR:	TO: C/S D SHOULDER(S) MID BACK(L) LOW BACK(R) HIP(R) UEB(L) UEB(R) LLE(L) RLE(R) HAN(L) WRIST(L) ELBOW(L) KNEE(L) ANKLE(L) FOOT(L) TIME: 10 MIN(L) 15 MIN(R) 20 MIN(L) 25 MIN(R) OTHER:		
MEOP:	TO: C/S D SHOULDER(S) MID BACK(L) LOW BACK(R) HIP(R) UEB(L) UEB(R) LLE(L) RLE(R) HAN(L) WRIST(L) ELBOW(L) KNEE(L) ANKLE(L) FOOT(L) TIME: 20 MIN(L) 25 MIN(R) OTHER:		
MEOP:	TO: C/S D SHOULDER(S) MID BACK(L) LOW BACK(R) HIP(R) UEB(L) UEB(R) LLE(L) RLE(R) HAN(L) WRIST(L) ELBOW(L) KNEE(L) ANKLE(L) FOOT(L) TIME: 20 MIN(L) 25 MIN(R) OTHER:		
OTHER:	IFPC<20 MINUTES(D) LASER(D) THERAPEUTIC ACTIVITY(D) OTHER(D)		
ASSESSMENT:	The patient is well C/O no S to T to P/S		
PLAN:	Cont to current POC S/14/11		

Kevin J. Sbroi, RPT

Kevin J. Sbroi, RPT

modality sheet

REFERRING PHYSICIAN:	RUE(L) UEB(R) LLE(L) RLE(R) HAN(L) WRIST(L) ELBOW(L) KNEE(L) ANKLE(L) FOOT(L) TIME: 10 MIN(L) 15 MIN(R) 20 MIN(L) 25 MIN(R) OTHER:		
REFERRING PHYSICIAN:	TO: C/S D SHOULDER(S) MID BACK(L) LOW BACK(R) HIP(R) UEB(L) UEB(R) LLE(L) RLE(R) HAN(L) WRIST(L) ELBOW(L) KNEE(L) ANKLE(L) FOOT(L) TIME: 30 MIN(L) 45 MIN(R) OTHER:		
MENT:	TO: C/S D SHOULDER(S) MID BACK(L) LOW BACK(R) HIP(R) UEB(L) UEB(R) LLE(L) RLE(R) HAN(L) WRIST(L) ELBOW(L) KNEE(L) ANKLE(L) FOOT(L) TIME: 20 MIN(L) 25 MIN(R) OTHER:		
OTHER:	IFPC<20 MINUTES(D) LASER(D) THERAPEUTIC ACTIVITY(D) OTHER(D)		
ESCAPE:	The patient is well C/O no S to T to P/S		

AS	<i>JK</i> Cont & current doc <i>D. Hoyer</i>	<i>JK</i> Cont & current doc <i>D. Hoyer</i>
PLAN	Kevin J. Sgrol, RPT	

Name: 3/17/11

Date:

Date: 4/21/11

✓

SUBJECTIVE	Pt stated the back is feeling better	Pt c/o back pain = 4-5/10
OBJECTIVE	No significant muscle tension	Pt has been in N.Y. past two wk's
NEURO RE-ED	TO: C/S D SHOULDERS, MID BACK, LOW BACK, HIP, R UEN L UED R LEN L LEN HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 10 MIN, 15 MIN, 20 MIN, 25 MIN, 30 MIN OTHER:	TO: C/S D SHOULDERS, MID BACK, LOW BACK, HIP, R UEN L UED R LEN L LEN HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 10 MIN, 15 MIN, 20 MIN, 25 MIN, 30 MIN, 35 MIN, 40 MIN OTHER:
MASSAGE	TO MUSCULATURE OF C/S D SHOULDERS, MID BACK, LOW BACK, HIP, R UEN L UED R LEN L LEN HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 20 MIN, 25 MIN, 30 MIN, 35 MIN, 40 MIN OTHER:	FA TO MUSCULATURE OF C/S D SHOULDERS, MID BACK, LOW BACK, HIP, R UEN L UED R LEN L LEN HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 20 MIN, 25 MIN, 30 MIN, 35 MIN, 40 MIN OTHER:
TAPE/TE	KINESIO TAPE: x1" x2" x3" LEUKO TAPE: x1" x2" x3" THERAPEUTIC EXERCISES: 15 MIN, 30 MIN, 45 MIN, 60 MIN SRB FLOW SHEET	KINESIO TAPE: x1" x2" x3" LEUKO TAPE: x1" x2" x3" THERAPEUTIC EXERCISES: 15 MIN, 30 MIN, 45 MIN, 60 MIN SEE FLOW SHEET
POINT	TO: C/S D SHOULDERS, MID BACK, LOW BACK, HIP, R UEN L UED R LEN L LEN HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT DEXAMETHASONE: x1 TREATMENT, x2 TREATMENTS (1 x24 MINUTES)	TO: C/S D SHOULDERS, MID BACK, LOW BACK, HIP, R UEN L UED R LEN L LEN HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT DEXAMETHASONE: x1 TREATMENT, x2 TREATMENTS (1 x24 MINUTES)
US	TO: C/S D SHOULDERS, MID BACK, LOW BACK, HIP, R UEN L UED R LEN L LEN HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 10 MIN, 15 MIN, 20 MIN, 25 MIN W/CM2: .5, 1.0, 1.5, 2.0, 2.5	TO: C/S D SHOULDERS, MID BACK, LOW BACK, HIP, R UEN L UED R LEN L LEN HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 10 MIN, 15 MIN, 20 MIN, 25 MIN W/CM2: .5, 1.0, 1.5, 2.0, 2.5
MANUAL	TO: C/S D SHOULDERS, MID BACK, LOW BACK, HIP, R UEN L UED R LEN L LEN HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 10 MIN, 15 MIN, 20 MIN, 25 MIN OTHER:	TO: C/S D SHOULDERS, MID BACK, LOW BACK, HIP, R UEN L UED R LEN L LEN HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 10 MIN, 15 MIN, 20 MIN, 25 MIN OTHER:
ANODYNE	TO: C/S D SHOULDERS, MID BACK, LOW BACK, HIP, R UEN L UED R LEN L LEN HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 30 MIN, 45 MIN OTHER:	TO: C/S D SHOULDERS, MID BACK, LOW BACK, HIP, R UEN L UED R LEN L LEN HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 30 MIN, 45 MIN OTHER:
MBCP	TO: C/S D SHOULDERS, MID BACK, LOW BACK, HIP, R UEN L UED R LEN L LEN HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 20 MIN, 25 MIN OTHER:	TO: C/S D SHOULDERS, MID BACK, LOW BACK, HIP, R UEN L UED R LEN L LEN HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 20 MIN, 25 MIN OTHER:
OTHER	IFC x 20 MINUTES LASER THERAPEUTIC ACTIVITY OTHER	IFC x 20 MINUTES LASER THERAPEUTIC ACTIVITY OTHER
ASSESSMENT	Pt is doing well c/o pain & to = to Pt	Pt is doing well c/o pain & to = to Pt
PLAN	Continue current doc XJ Sign it	Cont'd current doc XJ Sign it

Name: 2/17/11

Date:

Date: 3/3/11

SUBJECTIVE	Pt stated she has had Tingling in her hands	Pt cont'd to state Tingling is fact
OBJECTIVE	No S's - just equal	Mild trm muscular tension low back
NEURO REED	TO: C/S L SHOULDERSL MID BACK L LOW BACK R HIP L R UEL L UEL R LEL L LEL HAND L WRIST L ELBOW L KNEE L ANKLE L FOOT L TIME: 10 MIN L 15 MIN L 20 MIN L 25 MIN L OTHER:	TO: C/S L SHOULDERSL MID BACK L LOW BACK R HIP L R UEL L UEL R LEL L LEL HAND L WRIST L ELBOW L KNEE L ANKLE L FOOT L TIME: 10 MIN L 15 MIN L 20 MIN L 25 MIN L OTHER:
MASSAGE	TO MUSCULATURE OF: C/S L SHOULDERSL MID BACK L LOW BACK R HIP L R UEL L UEL R LEL L LEL HAND L WRIST L ELBOW L KNEE L ANKLE L FOOT L TIME: 20 MIN L 25 MIN L 30 MIN L 40 MIN L OTHER:	TO MUSCULATURE OF: C/S L SHOULDERSL MID BACK L LOW BACK R HIP L R UEL L UEL R LEL L LEL HAND L WRIST L ELBOW L KNEE L ANKLE L FOOT L TIME: 20 MIN L 25 MIN L 30 MIN L 40 MIN L OTHER:
TAPE/TE	KINESIO TAPE: x10 x20 x30 LEUKO TAPE: x10 x20 x30 THERAPEUTIC EXERCISES: 15 MIN L 30 MIN L 45 MIN L 60 MIN L SEE FLOW SHEET	KINESIO TAPE: x10 x20 x30 LEUKO TAPE: x10 x20 x30 THERAPEUTIC EXERCISES: 15 MIN L 30 MIN L 45 MIN L 60 MIN L SEE FLOW SHEET
IONTO	TO: C/S L SHOULDERSL MID BACK L LOW BACK R HIP L R UEL L UEL R LEL L LEL HAND L WRIST L ELBOW L KNEE L ANKLE L FOOT L DEXAMETHASONE L ACETIC ACID L x1 TREATMENT L x2 TREATMENTS L x24 MINUTES L	TO: C/S L SHOULDERSL MID BACK L LOW BACK R HIP L R UEL L UEL R LEL L LEL HAND L WRIST L ELBOW L KNEE L ANKLE L FOOT L DEXAMETHASONE L ACETIC ACID L x1 TREATMENT L x2 TREATMENTS L x24 MINUTES L
LS	TO: C/S L SHOULDERSL MID BACK L LOW BACK R HIP L R UEL L UEL R LEL L LEL HAND L WRIST L ELBOW L KNEE L ANKLE L FOOT L TIME: 10 MIN L 15 MIN L 20 MIN L 25 MIN L W/CM2: .5L 1.0L 1.5L 2.0L 2.5L	TO: C/S L SHOULDERSL MID BACK L LOW BACK R HIP L R UEL L UEL R LEL L LEL HAND L WRIST L ELBOW L KNEE L ANKLE L FOOT L TIME: 10 MIN L 15 MIN L 20 MIN L 25 MIN L W/CM2: .5L 1.0L 1.5L 2.0L 2.5L
MANUAL	TO: C/S L SHOULDERSL MID BACK L LOW BACK R HIP L R UEL L UEL R LEL L LEL HAND L WRIST L ELBOW L KNEE L ANKLE L FOOT L TIME: 10 MIN L 15 MIN L 20 MIN L 25 MIN L OTHER:	TO: C/S L SHOULDERSL MID BACK L LOW BACK R HIP L R UEL L UEL R LEL L LEL HAND L WRIST L ELBOW L KNEE L ANKLE L FOOT L TIME: 10 MIN L 15 MIN L 20 MIN L 25 MIN L OTHER:
ANODYNE	TO: C/S L SHOULDERSL MID BACK L LOW BACK R HIP L R UEL L UEL R LEL L LEL HAND L WRIST L ELBOW L KNEE L ANKLE L FOOT L TIME: 30 MIN L 45 MIN L OTHER:	TO: C/S L SHOULDERSL MID BACK L LOW BACK R HIP L R UEL L UEL R LEL L LEL HAND L WRIST L ELBOW L KNEE L ANKLE L FOOT L TIME: 30 MIN L 45 MIN L OTHER:
AC/CP	TO: C/S L SHOULDERSL MID BACK L LOW BACK R HIP L R UEL L UEL R LEL L LEL HAND L WRIST L ELBOW L KNEE L ANKLE L FOOT L TIME: 20 MIN L 25 MIN L OTHER:	TO: C/S L SHOULDERSL MID BACK L LOW BACK R HIP L R UEL L UEL R LEL L LEL HAND L WRIST L ELBOW L KNEE L ANKLE L FOOT L TIME: 20 MIN L 25 MIN L OTHER:
OTHER	IFC x20 MINUTES L LASER L THERAPEUTIC ACTIVITY L OTHER L	IFC x20 MINUTES L LASER L THERAPEUTIC ACTIVITY L OTHER L
ASSESSMENT	Pt tol'te well had no c/o pain P/S	Pt tol'te well had no c/o Tingling P/S
PLAN	Cont'd a current Rx 2/17/2011	Cont'd a current Rx 2/17/2011

SUBJECTIVE	Pt had no c/o red pain since last visit	Pt had no c/o red pain since last visit
OBJECTIVE	No signif spasm or segmental	No T-t muscle Tension Low Back
NEURO REF-ED	TO: C/S <input type="checkbox"/> SHOULDERS/L MID BACK/L LOW BACK/L HIP/L R/UE/L L/UE/L R/LE/L L/LE/L HAND/L WRIST/L ELBOW/L KNEE/L ANKLE/L FOOT/L TIME: 10 MIN, 15 MIN, 20 MIN, 25 MIN, 30 MIN OTHER:	TO: C/S <input type="checkbox"/> SHOULDERS/L MID BACK/L LOW BACK/L HIP/L R/UE/L L/UE/L R/LE/L L/LE/L HAND/L WRIST/L ELBOW/L KNEE/L ANKLE/L FOOT/L TIME: 10 MIN, 15 MIN, 20 MIN, 25 MIN, 30 MIN, 30 MIN OTHER:
MASSAGE	TO MUSCULATURE OF: C/S <input type="checkbox"/> SHOULDERS/L MID BACK/L LOW BACK/L HIP/L R/UE/L L/UE/L R/LE/L L/LE/L HAND/L WRIST/L ELBOW/L KNEE/L ANKLE/L FOOT/L TIME: 20 MIN, 25 MIN, 30 MIN, 30 MIN, 40 MIN OTHER: <i>fx</i>	TO MUSCULATURE OF: C/S <input type="checkbox"/> SHOULDERS/L MID BACK/L LOW BACK/L HIP/L R/UE/L L/UE/L R/LE/L L/LE/L HAND/L WRIST/L ELBOW/L KNEE/L ANKLE/L FOOT/L TIME: 20 MIN, 25 MIN, 30 MIN, 30 MIN, 40 MIN OTHER: <i>fx</i>
TAPE/TE	KINESIO TAPE: x10 x20 x30 LEUKO TAPE: x10 x20 x30 THERAPEUTIC EXERCISES: 15 MIN, 30 MIN, 45 MIN, 60 MIN SEE FLOW SHEET	KINESIO TAPE: x10 x20 x30 LEUKO TAPE: x10 x20 x30 THERAPEUTIC EXERCISES: 15 MIN, 30 MIN, 45 MIN, 60 MIN SEE FLOW SHEET
IONTOP	TO: C/S <input type="checkbox"/> SHOULDERS/L MID BACK/L LOW BACK/L HIP/L R/UE/L L/UE/L R/LE/L L/LE/L HAND/L WRIST/L ELBOW/L KNEE/L ANKLE/L FOOT/L DEXAMETHASONE <input type="checkbox"/> ACETIC ACID <input type="checkbox"/> x1 TREATMENT, x2 TREATMENTS, x24 MINUTES	TO: C/S <input type="checkbox"/> SHOULDERS/L MID BACK/L LOW BACK/L HIP/L R/UE/L L/UE/L R/LE/L L/LE/L HAND/L WRIST/L ELBOW/L KNEE/L ANKLE/L FOOT/L DEXAMETHASONE <input type="checkbox"/> ACETIC ACID <input type="checkbox"/> x1 TREATMENT, x2 TREATMENTS, x24 MINUTES
LS	TO: C/S <input type="checkbox"/> SHOULDERS/L MID BACK/L LOW BACK/L HIP/L R/UE/L L/UE/L R/LE/L L/LE/L HAND/L WRIST/L ELBOW/L KNEE/L ANKLE/L FOOT/L TIME: 10 MIN, 15 MIN, 20 MIN, 25 MIN W/CM2: .50, 1.00, 1.50, 2.00, 2.50	TO: C/S <input type="checkbox"/> SHOULDERS/L MID BACK/L LOW BACK/L HIP/L R/UE/L L/UE/L R/LE/L L/LE/L HAND/L WRIST/L ELBOW/L KNEE/L ANKLE/L FOOT/L TIME: 10 MIN, 15 MIN, 20 MIN, 25 MIN W/CM2: .50, 1.00, 1.50, 2.00, 2.50
MANUAL	TO: C/S <input type="checkbox"/> SHOULDERS/L MID BACK/L LOW BACK/L HIP/L R/UE/L L/UE/L R/LE/L L/LE/L HAND/L WRIST/L ELBOW/L KNEE/L ANKLE/L FOOT/L TIME: 10 MIN, 15 MIN, 20 MIN, 25 MIN OTHER:	TO: C/S <input type="checkbox"/> SHOULDERS/L MID BACK/L LOW BACK/L HIP/L R/UE/L L/UE/L R/LE/L L/LE/L HAND/L WRIST/L ELBOW/L KNEE/L ANKLE/L FOOT/L TIME: 10 MIN, 15 MIN, 20 MIN, 25 MIN OTHER:
ANODINE	TO: C/S <input type="checkbox"/> SHOULDERS/L MID BACK/L LOW BACK/L HIP/L R/UE/L L/UE/L R/LE/L L/LE/L HAND/L WRIST/L ELBOW/L KNEE/L ANKLE/L FOOT/L TIME: 30 MIN, 45 MIN OTHER:	TO: C/S <input type="checkbox"/> SHOULDERS/L MID BACK/L LOW BACK/L HIP/L R/UE/L L/UE/L R/LE/L L/LE/L HAND/L WRIST/L ELBOW/L KNEE/L ANKLE/L FOOT/L TIME: 30 MIN, 45 MIN OTHER:
MECP	TO: C/S <input type="checkbox"/> SHOULDERS/L MID BACK/L LOW BACK/L HIP/L R/UE/L L/UE/L R/LE/L L/LE/L HAND/L WRIST/L ELBOW/L KNEE/L ANKLE/L FOOT/L TIME: 20 MIN, 25 MIN OTHER:	TO: C/S <input type="checkbox"/> SHOULDERS/L MID BACK/L LOW BACK/L HIP/L R/UE/L L/UE/L R/LE/L L/LE/L HAND/L WRIST/L ELBOW/L KNEE/L ANKLE/L FOOT/L TIME: 20 MIN, 25 MIN OTHER:
OTHER	IFPC x20 MINUTES LASER THERAPEUTIC ACTIVITY OTHER	IFPC x20 MINUTES LASER THERAPEUTIC ACTIVITY OTHER
	Pt had no c/o pain <i>fx</i>	Pt still had no c/o pain <i>fx</i>
	Cont & current doc <i>Dr. Hayes, PT</i>	Cont & current doc <i>Dr. Hayes, PT</i>

Name:
Date:

1/25/11

Date:

2/1/11

SUBJCTIVE	Pt was to pneumonia c/o 7-18P. May be to T coughing	Pt now stated Tingly in rt hand. No c/o wth since last 7
OBJECTIVE	Mod t- muscle Tension Low Back	2BP = 30
NEURO REED	TO: C/S L SHOULDERSL MID BACKL LOW BACKL HIPL R UEL L UEL R LED L LEL HANDL WRISTL ELBOWL KNEEL ANKLEL FOOTL TIME: 10 MINI 15 MINI 20 MINI 25 MINI 30 MINI OTHER:	TO: C/S L SHOULDERSL MID BACKL LOW BACKL HIPL R UEL L UEL R LED L LEL HANDL WRISTL ELBOWL KNEEL ANKLEL FOOTL TIME: 10 MINI 15 MINI 20 MINI 25 MINI 30 MINI OTHER:
MASSAGE	TO MUSCULATURE OF: C/S L SHOULDERSL MID BACKL LOW BACKL HIPL R UEL L UEL R LED L LEL HANDL WRISTL ELBOWL KNEEL ANKLEL FOOTL TIME: 20 MINI 25 MINI 30 MINI 40 MINI OTHER:	TO MUSCULATURE OF: C/S L SHOULDERSL MID BACKL LOW BACKL HIPL R UEL L UEL R LED L LEL HANDL WRISTL ELBOWL KNEEL ANKLEL FOOTL TIME: 20 MINI 25 MINI 30 MINI 40 MINI OTHER: PA
TAPE/TE	KINESIO TAPE: x1L x2L x3L LEUKO TAPE: x1L x2L x3L THERAPEUTIC EXERCISES: 15 MINI 30 MINI 45 MINI 60 MINI SEE FLOW SHEET	KINESIO TAPE: x1L x2L x3L LEUKO TAPE: x1L x2L x3L THERAPEUTIC EXERCISES: 15 MINI 30 MINI 45 MINI 60 MINI SEE FLOW SHEET
IONTO	TO: C/S L SHOULDERSL MID BACKL LOW BACKL HIPL R UEL L UEL R LED L LEL HANDL WRISTL ELBOWL KNEEL ANKLEL FOOTL DEXAMETHASONEL x1TREATMENTL x2TREATMENTS L x24 MINUTESL	TO: C/S L SHOULDERSL MID BACKL LOW BACKL HIPL R UEL L UEL R LED L LEL HANDL WRISTL ELBOWL KNEEL ANKLEL FOOTL DEXAMETHASONEL x1TREATMENTL x2TREATMENTS L x24 MINUTESL
LS	TO: C/S L SHOULDERSL MID BACKL LOW BACKL HIPL R UEL L UEL R LED L LEL HANDL WRISTL ELBOWL KNEEL ANKLEL FOOTL TIME: 10 MINI 15 MINI 20 MINI 25 MINI W/CM2: 5L 1.0L 1.5L 2.0L 2.5L	TO: C/S L SHOULDERSL MID BACKL LOW BACKL HIPL R UEL L UEL R LED L LEL HANDL WRISTL ELBOWL KNEEL ANKLEL FOOTL TIME: 10 MINI 15 MINI 20 MINI 25 MINI W/CM2: 5L 1.0L 1.5L 2.0L 2.5L
MANUAL	TO: C/S L SHOULDERSL MID BACKL LOW BACKL HIPL R UEL L UEL R LED L LEL HANDL WRISTL ELBOWL KNEEL ANKLEL FOOTL TIME: 10 MINI 15 MINI 20 MINI 25 MINI OTHER:	TO: C/S L SHOULDERSL MID BACKL LOW BACKL HIPL R UEL L UEL R LED L LEL HANDL WRISTL ELBOWL KNEEL ANKLEL FOOTL TIME: 10 MINI 15 MINI 20 MINI 25 MINI OTHER:
ANODYNE	TO: C/S L SHOULDERSL MID BACKL LOW BACKL HIPL R UEL L UEL R LED L LEL HANDL WRISTL ELBOWL KNEEL ANKLEL FOOTL TIME: 30 MINI 45 MINI OTHER:	TO: C/S L SHOULDERSL MID BACKL LOW BACKL HIPL R UEL L UEL R LED L LEL HANDL WRISTL ELBOWL KNEEL ANKLEL FOOTL TIME: 30 MINI 45 MINI OTHER:
MECP	TO: C/S L SHOULDERSL MID BACKL LOW BACKL HIPL R UEL L UEL R LED L LEL HANDL WRISTL ELBOWL KNEEL ANKLEL FOOTL TIME: 20 MINI 25 MINI OTHER:	TO: C/S L SHOULDERSL MID BACKL LOW BACKL HIPL R UEL L UEL R LED L LEL HANDL WRISTL ELBOWL KNEEL ANKLEL FOOTL TIME: 20 MINI 25 MINI OTHER:
OTHER	IFCx20 MINUTESL LASERL THERAPEUTIC ACTIVITYL OTHERL	IFCx20 MINUTESL LASERL THERAPEUTIC ACTIVITYL OTHERL
ASSESSMENT	Pt tol the well to no c/o pain to R	Pt tol the well to 18P & to = to R
PLAN	Cont & current doc D. Nagy, PT	Cont & current doc D. Nagy, PT

Name: 1/11/11

Date: 1/18/11

SUBJECTIVE	Pt c/o Tingly B ft. Since last pt	Pt still c/o tingly B ft. Also c/o a sensation as if H2O is running down the back of the legs
OBJECTIVE	No r = a tinge just	
NEURO RE-ED	TO: C/S U SHOULDERS, MID BACK, LOW BACK, HIP, R UED, L UED, R LEN, L LEO, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 10 MIN, 15 MIN, 20 MIN, 25 MIN OTHER:	TO: C/S U SHOULDERS, MID BACK, LOW BACK, HIP, R UED, L UED, R LEN, L LEO, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 10 MIN, 15 MIN, 20 MIN, 25 MIN OTHER:
MASSAGE	TO MUSCULATURE OF C/S U SHOULDERS, MID BACK, LOW BACK, HIP, R UED, L UED, R LEN, L LEO, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 20 MIN, 25 MIN, 30 MIN, 40 MIN OTHER:	TO MUSCULATURE OF C/S U SHOULDERS, MID BACK, LOW BACK, HIP, R UED, L UED, R LEN, L LEO, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 20 MIN, 25 MIN, 30 MIN, 40 MIN OTHER:
TAPE/TE	KINESIO TAPE: x10 x20 x30 LEUKO TAPE: x10 x20 x30 THERAPEUTIC EXERCISES: 15 MIN, 30 MIN, 45 MIN, 60 MIN SEE FLOW SHEET	KINESIO TAPE: x10 x20 x30 LEUKO TAPE: x10 x20 x30 THERAPEUTIC EXERCISES: 15 MIN, 30 MIN, 45 MIN, 60 MIN SEE FLOW SHEET
IONTO	TO: C/S U SHOULDERS, MID BACK, LOW BACK, HIP, R UED, L UED, R LEN, L LEO, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT DEXAMETHASONE, ACETIC ACID x1 TREATMENT x2 TREATMENTS x24 MINUTES	TO: C/S U SHOULDERS, MID BACK, LOW BACK, HIP, R UED, L UED, R LEN, L LEO, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT DEXAMETHASONE, ACETIC ACID x1 TREATMENT x2 TREATMENTS x24 MINUTES
US	TO: C/S U SHOULDERS, MID BACK, LOW BACK, HIP, R UED, L UED, R LEN, L LEO, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 10 MIN, 15 MIN, 20 MIN, 25 MIN W/CM2: .50, 1.00, 1.50, 2.00, 2.50	TO: C/S U SHOULDERS, MID BACK, LOW BACK, HIP, R UED, L UED, R LEN, L LEO, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 10 MIN, 15 MIN, 20 MIN, 25 MIN W/CM2: .50, 1.00, 1.50, 2.00, 2.50
MANUAL	TO: C/S U SHOULDERS, MID BACK, LOW BACK, HIP, R UED, L UED, R LEN, L LEO, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 10 MIN, 15 MIN, 20 MIN, 25 MIN OTHER:	TO: C/S U SHOULDERS, MID BACK, LOW BACK, HIP, R UED, L UED, R LEN, L LEO, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 10 MIN, 15 MIN, 20 MIN, 25 MIN OTHER:
ANODYNE	TO: C/S U SHOULDERS, MID BACK, LOW BACK, HIP, R UED, L UED, R LEN, L LEO, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 30 MIN, 45 MIN OTHER:	TO: C/S U SHOULDERS, MID BACK, LOW BACK, HIP, R UED, L UED, R LEN, L LEO, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 30 MIN, 45 MIN OTHER:
MECP	TO: C/S U SHOULDERS, MID BACK, LOW BACK, HIP, R UED, L UED, R LEN, L LEO, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 20 MIN, 25 MIN OTHER:	TO: C/S U SHOULDERS, MID BACK, LOW BACK, HIP, R UED, L UED, R LEN, L LEO, HAND, WRIST, ELBOW, KNEE, ANKLE, FOOT TIME: 20 MIN, 25 MIN OTHER:
OTHER	IFC x20 MINUTES LASER THERAPEUTIC ACTIVITY OTHER:	IFC x20 MINUTES LASER THERAPEUTIC ACTIVITY OTHER:
ASSESSMENT	Pt still c/o well c/o Tingly to ft	Pt still c/o well had no c/o pain to R
PLAN	Cont to current doc Dr. Nagy, PT	Cont to current doc Dr. Nagy, PT 72

Name: 17/14/10		Date: 1/4/10
SUBJECTIVE	Pt had no crp and pain to side last 8	Pt had pain over neck 2 wk, also crp. Tension in ft & leg.
OBJECTIVE	No trm muscle tension crp/hand/neck	Pt stated after playing for a little while PLEs become very tired
NEURO RE-ED	TO: C/S L SHOULDERS MID BACK R LOW BACK L HIP R UED L UED R LED L LED HAND R WRIST R ELBOW L KNEE R ANKLE R FOOT TIME: 10 MIN 15 MIN 20 MIN 25 MIN OTHER:	TO: C/S L SHOULDERS MID BACK R LOW BACK L HIP R UED L UED R LED L LED HAND R WRIST R ELBOW L KNEE R ANKLE R FOOT TIME: 10 MIN 15 MIN 20 MIN 25 MIN OTHER:
MESSAGE	TO MUSCULATURE OF: C/S L SHOULDERS MID BACK R LOW BACK L HIP R UED L UED R LED L LED HAND R WRIST R ELBOW L KNEE R ANKLE R FOOT TIME: 20 MIN 25 MIN 30 MIN 40 MIN OTHER:	TO MUSCULATURE OF: C/S L SHOULDERS MID BACK R LOW BACK L HIP R UED L UED R LED L LED HAND R WRIST R ELBOW L KNEE R ANKLE R FOOT TIME: 20 MIN 25 MIN 30 MIN 40 MIN OTHER:
TAPETTE	KINESIO TAPE: x10 x20 x30 LEUKO TAPE: x10 x20 x30 THERAPEUTIC EXERCISES: 15 MIN 30 MIN 45 MIN 60 MIN SEE FLOW SHEET	KINESIO TAPE: x10 x20 x30 LEUKO TAPE: x10 x20 x30 THERAPEUTIC EXERCISES: 15 MIN 30 MIN 45 MIN 60 MIN SEE FLOW SHEET
IONTO	TO: C/S L SHOULDERS MID BACK R LOW BACK L HIP R UED L UED R LED L LED HAND R WRIST R ELBOW L KNEE R ANKLE R FOOT DEXAMETHASONE x1 TREATMENT x2 TREATMENTS x24 MINUTES	TO: C/S L SHOULDERS MID BACK R LOW BACK L HIP R UED L UED R LED L LED HAND R WRIST R ELBOW L KNEE R ANKLE R FOOT DEXAMETHASONE x1 TREATMENT x2 TREATMENTS x24 MINUTES
LS	TO: C/S L SHOULDERS MID BACK R LOW BACK L HIP R UED L UED R LED L LED HAND R WRIST R ELBOW L KNEE R ANKLE R FOOT TIME: 10 MIN 15 MIN 20 MIN 25 MIN W/CM2: .50 1.00 1.50 2.00 2.50	TO: C/S L SHOULDERS MID BACK R LOW BACK L HIP R UED L UED R LED L LED HAND R WRIST R ELBOW L KNEE R ANKLE R FOOT TIME: 10 MIN 15 MIN 20 MIN 25 MIN W/CM2: .50 1.00 1.50 2.00 2.50
MATUAL	TO: C/S L SHOULDERS MID BACK R LOW BACK L HIP R UED L UED R LED L LED HAND R WRIST R ELBOW L KNEE R ANKLE R FOOT TIME: 10 MIN 15 MIN 20 MIN 25 MIN OTHER:	TO: C/S L SHOULDERS MID BACK R LOW BACK L HIP R UED L UED R LED L LED HAND R WRIST R ELBOW L KNEE R ANKLE R FOOT TIME: 10 MIN 15 MIN 20 MIN 25 MIN OTHER:
ANODINE	TO: C/S L SHOULDERS MID BACK R LOW BACK L HIP R UED L UED R LED L LED HAND R WRIST R ELBOW L KNEE R ANKLE R FOOT TIME: 30 MIN 45 MIN OTHER:	TO: C/S L SHOULDERS MID BACK R LOW BACK L HIP R UED L UED R LED L LED HAND R WRIST R ELBOW L KNEE R ANKLE R FOOT TIME: 30 MIN 45 MIN OTHER:
MECP	TO: C/S L SHOULDERS MID BACK R LOW BACK L HIP R UED L UED R LED L LED HAND R WRIST R ELBOW L KNEE R ANKLE R FOOT TIME: 20 MIN 25 MIN OTHER:	TO: C/S L SHOULDERS MID BACK R LOW BACK L HIP R UED L UED R LED L LED HAND R WRIST R ELBOW L KNEE R ANKLE R FOOT TIME: 20 MIN 25 MIN OTHER:
OTHER	IFC x20 MINUTES LASER THERAPEUTIC ACTIVITY OTHER:	IFC x20 MINUTES LASER THERAPEUTIC ACTIVITY OTHER:
ASSESSMENT	Pt had the well had no crp pain P.R.	Pt had the well minor trm muscle tension low back
PLAN	Cont to current doc X-Ref to PT	Cont to current doc D. N. G. 73

Name [REDACTED]

Date: 11/30/10

Date: 12/19/10

SUBJECTIVE	PT c/o c/s/upper thoracic pain Pain = <u>3</u> /10	PT stated she had c/s since last pt Nov 20 - upper thoracic area
OBJECTIVE	mod muscle tension & c/s upper thoracic	mod & in muscle tension to back
NEURO RE-ED	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP R UEO L UEO R LEO L LEO HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN OTHER:	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP R UEO L UEO R LEO L LEO HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN OTHER:
MASSAGE	TO MUSCULATURE OF: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP R UEO L UEO R LEO L LEO HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT TIME: 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> 30 MIN <input type="checkbox"/> 40 MIN OTHER:	TO MUSCULATURE OF: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP R UEO L UEO R LEO L LEO HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT TIME: 20 MIN <input type="checkbox"/> 25 MIN <input type="checkbox"/> 30 MIN <input type="checkbox"/> 40 MIN OTHER:
TAPE/TE	KINESIO TAPE: <input type="checkbox"/> x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3 LEUKO TAPE: <input type="checkbox"/> x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3 THERAPEUTIC EXERCISES: 15 MIN <input type="checkbox"/> 30 MIN <input type="checkbox"/> 45 MIN <input type="checkbox"/> 60 MIN SEE FLOW SHEET	KINESIO TAPE: <input type="checkbox"/> x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3 LEUKO TAPE: <input type="checkbox"/> x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3 THERAPEUTIC EXERCISES: 15 MIN <input type="checkbox"/> 30 MIN <input type="checkbox"/> 45 MIN <input type="checkbox"/> 60 MIN SEE FLOW SHEET
POINT	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP R UEO L UEO R LEO L LEO HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT DEXAMETHASONE <input type="checkbox"/> ACETIC ACID <input type="checkbox"/> x1 TREATMENT <input type="checkbox"/> x2 TREATMENTS <input type="checkbox"/> x24 MINUTES	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP R UEO L UEO R LEO L LEO HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT DEXAMETHASONE <input type="checkbox"/> ACETIC ACID <input type="checkbox"/> x1 TREATMENT <input type="checkbox"/> x2 TREATMENTS <input type="checkbox"/> x24 MINUTES
US	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP R UEO L UEO R LEO L LEO HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN W/CM2: .50 1.00 1.50 2.00 2.50	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP R UEO L UEO R LEO L LEO HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN W/CM2: .50 1.00 1.50 2.00 2.50
MANUAL	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP R UEO L UEO R LEO L LEO HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN OTHER:	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP R UEO L UEO R LEO L LEO HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT TIME: 10 MIN <input type="checkbox"/> 15 MIN <input type="checkbox"/> 20 MIN <input type="checkbox"/> 25 MIN OTHER:
ANODYNE	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP R UEO L UEO R LEO L LEO HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT TIME: 30 MIN <input type="checkbox"/> 45 MIN OTHER:	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP R UEO L UEO R LEO L LEO HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT TIME: 30 MIN <input type="checkbox"/> 45 MIN OTHER:
MECP	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP R UEO L UEO R LEO L LEO HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT TIME: 20 MIN <input type="checkbox"/> 25 MIN OTHER:	TO: C/S <input type="checkbox"/> SHOULDERS <input type="checkbox"/> MID BACK <input type="checkbox"/> LOW BACK <input type="checkbox"/> HIP R UEO L UEO R LEO L LEO HAND <input type="checkbox"/> WRIST <input type="checkbox"/> ELBOW <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT TIME: 20 MIN <input type="checkbox"/> 25 MIN OTHER:
OTHER	JFC x20 MINUTES <input type="checkbox"/> LASER <input type="checkbox"/> THERAPEUTIC ACTIVITY <input type="checkbox"/> OTHER <input type="checkbox"/>	JFC x20 MINUTES <input type="checkbox"/> LASER <input type="checkbox"/> THERAPEUTIC ACTIVITY <input type="checkbox"/> OTHER <input type="checkbox"/>
ASSESSMENT	PT did well c/o sci & it is to <input type="checkbox"/> <input type="checkbox"/>	PT did well had no c/o H/O P/T
PLAN	cont c. current doc XJ 1/10/11	cont c. current doc XJ 1/10/11

07/17/2012 13:16 FAX

010

Name:
Date: 10-26-10

Date: 11/9/10

SUBJECTIVE	Pt mother stated [REDACTED] stated her leg [REDACTED] felt like jelly	Pt had no c/o jelly like feeling in legs
OBJECTIVE	2. Trace To the WR	No antalgic part
NEURO EEG	TO: C/S I SHOULDERS I MID BACK I LOW BACK I HIP I R UEL I L UEL R LEL I L LEL HAN D Wrist I ELBOW I KNEE I ANKLE I FOOT I TIME: 10 MIN I 15 MIN I 20 MIN I 25 MIN OTHER:	TO: C/S I SHOULDERS I MID BACK I LOW BACK I HIP I R UEL I L UEL R LEL I L LEL HAN D Wrist I ELBOW I KNEE I ANKLE I FOOT I TIME: 10 MIN I 15 MIN I 20 MIN I 25 MIN OTHER:
MASSAGE	TO MUSCULATURE OF: C/S I SHOULDERS I MID BACK I LOW BACK I HIP I R UEL I L UEL R LEL I L LEL HAN D Wrist I ELBOW I KNEE I ANKLE I FOOT I TIME: 20 MIN I 25 MIN I 30 MIN I 40 MIN OTHER:	TO MUSCULATURE OF: C/S I SHOULDERS I MID BACK I LOW BACK I HIP I R UEL I L UEL R LEL I L LEL HAN D Wrist I ELBOW I KNEE I ANKLE I FOOT I TIME: 20 MIN I 25 MIN I 30 MIN I 40 MIN OTHER:
TAPE/TE	KINESIO TAPE: x10 I x2 I x3 I LEUKO TAPE: x10 I x2 I x3 I THERAPEUTIC EXERCISES: 15 MIN I 30 MIN I 45 MIN I 60 MIN SEE FLOW SHEET	KINESIO TAPE: x10 I x2 I x3 I LEUKO TAPE: x10 I x2 I x3 I THERAPEUTIC EXERCISES: 15 MIN I 30 MIN I 45 MIN I 60 MIN SEE FLOW SHEET
IONTO	TO: C/S I SHOULDERS I MID BACK I LOW BACK I HIP I R UEL I L UEL R LEL I L LEL HAN D Wrist I ELBOW I KNEE I ANKLE I FOOT I DEXAMETHASONE I ACETIC ACID I x1 TREATMENT I x2 TREATMENTS I x24 MINUTES I	TO: C/S I SHOULDERS I MID BACK I LOW BACK I HIP I R UEL I L UEL R LEL I L LEL HAN D Wrist I ELBOW I KNEE I ANKLE I FOOT I DEXAMETHASONE I ACETIC ACID I x1 TREATMENT I x2 TREATMENTS I x24 MINUTES I
US	TO: C/S I SHOULDERS I MID BACK I LOW BACK I HIP I R UEL I L UEL R LEL I L LEL HAN D Wrist I ELBOW I KNEE I ANKLE I FOOT I TIME: 10 MIN I 15 MIN I 20 MIN I 25 MIN W/CM2: .5 I 1.0 I 1.5 I 2.0 I 2.5 I	TO: C/S I SHOULDERS I MID BACK I LOW BACK I HIP I R UEL I L UEL R LEL I L LEL HAN D Wrist I ELBOW I KNEE I ANKLE I FOOT I TIME: 10 MIN I 15 MIN I 20 MIN I 25 MIN W/CM2: .5 I 1.0 I 1.5 I 2.0 I 2.5 I
MANU	TO: C/S I SHOULDERS I MID BACK I LOW BACK I HIP I R UEL I L UEL R LEL I L LEL HAN D Wrist I ELBOW I KNEE I ANKLE I FOOT I TIME: 10 MIN I 15 MIN I 20 MIN I 25 MIN OTHER:	TO: C/S I SHOULDERS I MID BACK I LOW BACK I HIP I R UEL I L UEL R LEL I L LEL HAN D Wrist I ELBOW I KNEE I ANKLE I FOOT I TIME: 10 MIN I 15 MIN I 20 MIN I 25 MIN
ANODINE	TO: C/S I SHOULDERS I MID BACK I LOW BACK I HIP I R UEL I L UEL R LEL I L LEL HAN D Wrist I ELBOW I KNEE I ANKLE I FOOT I TIME: 30 MIN I 45 MIN OTHER:	TO: C/S I SHOULDERS I MID BACK I LOW BACK I HIP I R UEL I L UEL R LEL I L LEL HAN D Wrist I ELBOW I KNEE I ANKLE I FOOT I TIME: 30 MIN I 45 MIN OTHER:
NEURO	TO: C/S I SHOULDERS I MID BACK I LOW BACK I HIP I R UEL I L UEL R LEL I L LEL HAN D Wrist I ELBOW I KNEE I ANKLE I FOOT I TIME: 20 MIN I 25 MIN OTHER:	TO: C/S I SHOULDERS I MID BACK I LOW BACK I HIP I R UEL I L UEL R LEL I L LEL HAN D Wrist I ELBOW I KNEE I ANKLE I FOOT I TIME: 20 MIN I 25 MIN OTHER:
OTHER	IFC x20 MINUTES I LASER I THERAPEUTIC ACTIVITY I OTHER I	IFC x20 MINUTES I LASER I THERAPEUTIC ACTIVITY I OTHER I
ASSESSMENT	Pt tol well had no c/o pain to R	Pt tol well had no c/o pain to R
PLAN	Cont to current rx SLR in 1 w.	Cont to current rx SLR in 1 w.

75



Treatment Note

Joshua Tree Physical Therapy
Hayden
8475 N. Government Way
Suite 102
Hayden, ID 83835
tel: (208) 772-9774
fax: (208) 772-9564

Patient: [REDACTED]
Gender: F
DOB: [REDACTED]

Injury Date: 10/15/2010
Evaluation Date: 03/10/2011
Visit #11: 12/15/2011

Therapist of Record: Kevin J Sgrol PT
Referring Practitioner: Ronda Westcott MD

Provider: Kevin J Sgrol PT
Provider Email: kevin@joshuatreept.com

#	Medical Diagnoses	ICD-9
1)	Lumbago (Back Pain)	724.2

#	Treating Diagnoses	ICD-9
1)	Lumbar segmental dysfunction	739.3
2)	Lumbar sprain and strain	847.2
3)	Muscle spasm	728.86
4)	Musculoskeletal surgical aftercare	V88.78

Patient Status

The patient stated that she had to go to school nurse secondary complaints of headaches and low back pain.

Measures

The following measures were identified for the patient's Lumbar Spine condition:

Measure	Initial (03/10/2011)	Current (12/15/2011)	Target
Standing weight-shift (symptoms) Shifting weight from one leg to the other while standing without symptoms	Severe difficulty; 50 % weight bearing on 1 leg produces symptoms	Severe difficulty; 50 % weight bearing on 1 leg produces symptoms	No difficulty; Bears full weight on 1 leg without symptoms
Sitting (capacity) Ability to sit	Severe difficulty; Only able to sit < 1 hour/day	Severe difficulty; Only able to sit < 1 hour/day	No difficulty; Sitting capability is unlimited
Standing (capacity) Ability to stand	Severe difficulty; Only able to stand < 1 hour/day	Severe difficulty; Only able to stand < 1 hour/day	No difficulty; Standing capability is unlimited
Walking medium distances (symptoms) Walking medium distances without symptoms	Severe problem; Only able to walk < 100 yards without symptoms	Severe problem; Only able to walk < 100 yards without symptoms	No problem; Able to walk > 1000 yards without symptoms
Pain (at rest) Current level of pain	Mild pain; 1/10 to 2/10	Mild pain; 1/10 to 2/10	No pain; 0/10
Pain (at worst) Highest level of pain during the last 24 hours	Severe pain; 6/10 to 9/10	Moderate pain; 3/10 to 5/10	No pain; 0/10
Pain (with movement) Highest level of pain while performing the most aggravating movement	Severe pain; 6/10 to 9/10	Mild pain; 1/10 to 2/10	No pain; 0/10

Measure	Initial (03/10/2011)	Current (12/16/2011)	Target
AROM / Pain (lumbar extension) Movement / pain relations with active lumbar extension	Severe impairment: Pain during initial ranges of active lumbar extension	Moderate impairment: Pain during mid ranges of active lumbar extension	No impairment; No pain with active lumbar extension
AROM / Pain (lumbar flexion) Movement / pain relations with active lumbar flexion	Mild impairment: Pain only at end ranges of active lumbar flexion	Mild impairment: Pain only at end ranges of active lumbar flexion	No impairment: No pain with active lumbar flexion
Flexibility / Muscle length (hip extension / Iliacus) Iliacus flexibility	Moderate extension flexibility deficits: -10° to 0°	Moderate extension flexibility deficits: -10° to 0°	Normal extension flexibility: > 10° of hip extension
Flexibility / Muscle length (hamstring / straight leg raise) Hamstring flexibility assessed using the straight leg raising test	Moderate straight leg raise flexibility deficits: 40° to 49°	Moderate straight leg raise flexibility deficits: 40° to 49°	Normal straight leg raise flexibility: > 60°
Strength (lumbar extensors) Lumbar extensors muscle test grade	Moderate weakness: 3/5 strength	Moderate weakness: 3/5 strength	Normal: 6/6 strength
Oswestry Low Back Pain Disability Index (ODI) Score on the Modified Oswestry Low Back Disability Index (ODI)	Severe activity limitation; ODI score 41 to 80	Moderate activity limitation; ODI score 21 to 40	No activity limitation; ODI score 0 to 4

Additional Evaluative Findings

patient had no complaints of numbness/tingling into the bilateral lower extremities.

Treatment Provided Today

The following interventions were performed for the patient's lumbar spine condition:

Massage Therapy (97124):

Cold Laser (97039):

Infrared / Anodyne (07026):

Provider Interactions With Patient During Visit

Verbal and manual cuing on proper performance of the movement.

Assessment

The examination of [REDACTED] identified low back mobility deficits associated with a current post-operative condition. Physical therapy intervention strategies designed to address these impairments will be instrumental in achieving the stated functional goals, including her ability to perform walking tasks. The additional presence of chronic pain in the involved region will likely impact the frequency of physical therapy interventions and will be addressed throughout the episode of care. Based on the examination, the patient's rehabilitation potential to achieve functional goals is excellent.

Functional Goal	Patient Progress

Low back pain will improve to be able to bend below the waist and lift 10lbs intermittently for 4 hours daily for occupational activities; Timeframe: 16 weeks.

The patient reports a reduction in symptoms and improvement in function of more than 60% since initiating therapy. Achieving the patient's goals with continued therapy is expected.

Pelvic girdle pain and strength will improve to be able to weight shift with prolonged standing and walking for 2 hours daily for occupational activities; Timeframe: 16 weeks.

The patient reports a reduction in symptoms and improvement in function of more than 50 % since initiating therapy. Achieving the patient's goals with continued therapy is expected.

Plan

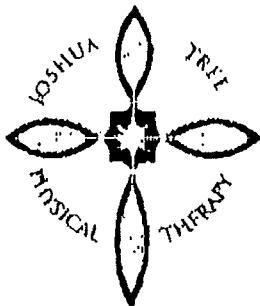
At the next visit, the preferred treatment order is: 1. Modalities, 2. Activities and Exercises, 3. Manual Therapy.

Treatment Time

20 minutes direct contact (lmed) with patient.
50 minutes total treatment time.

Therapist Signature(s)

Electronically signed by Kevin J Sgroi PT on 12/15/2011 1:11:230 PST



Treatment Note

Joshua Tree Physical Therapy
Hayden
8475 N. Government Way
Suite 102
Hayden, ID 83835
tel: (208) 772-9774
fax: (208) 772-9564

Patient: [REDACTED]
Gender: F
DOB: [REDACTED]

Therapist of Record: Kevin J Sgrol PT
Referring Practitioner: Ronda Westcott MD

Injury Date: 10/15/2010
Evaluation Date: 03/10/2011
Visit #10: 12/06/2011

Provider: Kevin J Sgrol PT
Provider Email: kevin@joshuatreept.com

#	Medical Diagnoses	ICD-9
1)	Lumbago (Back Pain)	724.2

#	Treating Diagnoses	ICD-9
1)	Lumbar segmental dysfunction	739.3
2)	Lumbar sprain and strain	847.2
3)	Muscle spasm	728.86
4)	Musculoskeletal surgical aftercare	V88.78

Patient Status

Patient stated that when she bends forward or low back hurts. Patient also complains of headaches on occasion however, unsure frequency.

Measures

The following measures were identified for the patient's Lumbar Spine condition:

Measure	Initial (03/10/2011)	Current (12/06/2011)	Target
Standing weight-shift (symptoms) Shifting weight from one leg to the other while standing without symptoms	Severe difficulty; 50 % weight bearing on 1 leg produces symptoms	Severe difficulty; 50 % weight bearing on 1 leg produces symptoms	No difficulty; Bears full weight on 1 leg without symptoms
Sitting (capacity) Ability to sit	Severe difficulty; Only able to sit < 1 hour/day	Severe difficulty; Only able to sit < 1 hour/day	No difficulty; Sitting capability is unlimited
Standing (capacity) Ability to stand	Severe difficulty; Only able to stand < 1 hour/day	Severe difficulty; Only able to stand < 1 hour/day	No difficulty; Standing capability is unlimited
Walking medium distances (symptoms) Walking medium distances without symptoms	Severe problem; Only able to walk < 100 yards without symptoms	Severe problem; Only able to walk < 100 yards without symptoms	No problem; Able to walk > 1000 yards without symptoms
Pain (at rest) Current level of pain	Mild pain: 1/10 to 2/10	Mild pain: 1/10 to 2/10	No pain: 0/10
Pain (at worst) Highest level of pain during the last 24 hours	Severe pain: 6/10 to 9/10	Moderate pain: 3/10 to 5/10	No pain: 0/10
Pain (with movement) Highest level of pain while performing the most aggravating movement	Severe pain: 6/10 to 9/10	Mild pain: 1/10 to 2/10	No pain: 0/10

Measure	Initial (03/10/2011)	Current (12/06/2011)	Target
AROM / Pain (lumbar extension) Movement / pain relations with active lumbar extension	Severe Impairment: Pain during initial ranges of active lumbar extension	Moderate impairment: Pain during mid ranges of active lumbar extension	No impairment: No pain with active lumbar extension
AROM / Pain (lumbar flexion) Movement / pain relations with active lumbar flexion	Mild Impairment: Pain only at end ranges of active lumbar flexion	Mild Impairment: Pain only at end ranges of active lumbar flexion	No impairment: No pain with active lumbar flexion
Flexibility / Muscle length (hip extension / Iliacus) Iliacus flexibility	Moderate extension flexibility deficits: -10° to 0°	Moderate extension flexibility deficits: -10° to 0°	Normal extension flexibility: > 10° of hip extension
Flexibility / Muscle length (hamstring / straight leg raise) Hamstring flexibility assessed using the straight leg raising test	Moderate straight leg raise flexibility deficits: 40° to 49°	Moderate straight leg raise flexibility deficits: 40° to 49°	Normal straight leg raise flexibility: > 80°
Strength (lumbar extensors) Lumbar extensor muscle test grade	Moderate weakness: 3/5 strength	Moderate weakness: 3/5 strength	Normal: 5/5 strength
Oswestry Low Back Pain Disability Index (ODI) Score on the Modified Oswestry Low Back Disability Index (ODI)	Severe activity limitation: ODI score 41 to 80	Moderate activity limitation: ODI score 21 to 40	No activity limitation: ODI score 0 to 4

Additional Evaluative Findings

patient had no complaints of numbness/tingling into the bilateral lower extremities.

Treatment Provided Today

The following interventions were performed for the patient's lumbar spine condition:

Massage Therapy (97124):

Cold Laser (97039):

Infrared / Anodyne (97026):

Provider Interactions With Patient During Visit

Verbal cueing on proper performance of the movement.

Assessment

The examination of [REDACTED] identified low back mobility deficits associated with a current post-operative condition. Physical therapy intervention strategies designed to address these impairments will be instrumental in achieving the stated functional goals, including her ability to perform walking tasks. The additional presence of chronic pain in the involved region will likely impact the frequency of physical therapy interventions and will be addressed throughout the episode of care. Based on the examination, the patient's rehabilitation potential to achieve functional goals is excellent.

Functional Goal	Patient Progress

Low back pain will improve to be able to bend below the waist and lift 10lbs intermittently for 4 hours daily for occupational activities; Timeframe: 16 weeks.	The patient reports a reduction in symptoms and improvement in function of more than 60% since initiating therapy. Achieving the patient's goals with continued therapy is expected.
Pelvic girdle pain and strength will improve to be able to weight shift with prolonged standing and walking for 2 hours daily for occupational activities; Timeframe: 16 weeks.	The patient reports a reduction in symptoms and improvement in function of more than 50 % since initiating therapy. Achieving the patient's goals with continued therapy is expected.

Plan

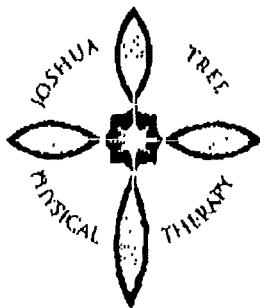
At the next visit, the preferred treatment order is: 1. Modalities, 2. Activities and Exercises, 3. Manual Therapy.

Treatment Time

20 minutes direct contact (timed) with patient.
50 minutes total treatment time.

Therapist Signature(s)

electronically signed by Kevin J. Sgouros PT on 12/07/2011 1:12:05 PST



Treatment Note

Joshua Tree Physical Therapy
Hayden
8475 N. Government Way
Suite 102
Hayden, ID 83836
tel: (208) 772-9774
fax: (208) 772-9564

Patient: [REDACTED]
Gender: F
DOB: [REDACTED]

Injury Date: 10/16/2010
Evaluation Date: 03/10/2011
Visit #8: 11/22/2011

Therapist of Record: Kevin J Sgroi PT
Referring Practitioner: Ronde Westcott MD

Provider: Kevin J Sgroi PT
Provider Email: kevin@joshuatreept.com

# Medical Diagnoses	ICD-9
1) Lumbago (Back Pain)	724.2

# Treating Diagnoses	ICD-9
1) Lumbar segmental dysfunction	739.3
2) Lumbar sprain and strain	847.2
3) Muscle spasm	720.85
4) Musculoskeletal surgical aftercare	V66.78

Patient Status

Patient stated that when she bends forward or low back hurts. Patient also complains of headaches on occasion however, unsure frequency.

Measures

The following measures were identified for the patient's Lumbar Spine condition:

Measure	Initial (03/10/2011)	Current (11/22/2011)	Target
Standing weight-shift (symptoms) Shifting weight from one leg to the other while standing without symptoms	Severe difficulty; 50 % weight bearing on 1 leg produces symptoms	Severe difficulty; 50 % weight bearing on 1 leg produces symptoms	No difficulty: Bear full weight on 1 leg without symptoms
Sitting (capacity) Ability to sit	Severe difficulty; Only able to sit < 1 hour/day	Severe difficulty; Only able to sit < 1 hour/day	No difficulty: Sitting capability is unlimited
Standing (capacity) Ability to stand	Severe difficulty; Only able to stand < 1 hour/day	Severe difficulty; Only able to stand < 1 hour/day	No difficulty; Standing capability is unlimited
Walking medium distances (symptoms) Walking medium distances without symptoms	Severe problem; Only able to walk < 100 yards without symptoms	Severe problem; Only able to walk < 100 yards without symptoms	No problem; Able to walk > 1000 yards without symptoms
Pain (at rest) Current level of pain	Mild pain; 1/10 to 2/10	Mild pain; 1/10 to 2/10	No pain; 0/10
Pain (at worst) Highest level of pain during the last 24 hours	Severe pain; 6/10 to 9/10	Moderate pain; 3/10 to 5/10	No pain; 0/10
Pain (with movement) Highest level of pain while performing the most aggravating movement	Severe pain; 6/10 to 9/10	Mild pain; 1/10 to 2/10	No pain; 0/10

Measure	Initial (09/10/2011)	Current (11/22/2011)	Target
AROM / Pain (lumbar extension) Movement / pain relations with active lumbar extension	Severe impairment; Pain during initial ranges of active lumbar extension	Severe impairment; Pain during initial ranges of active lumbar extension	No impairment; No pain with active lumbar extension
AROM / Pain (lumbar flexion) Movement / pain relations with active lumbar flexion	Mild impairment; Pain only at end ranges of active lumbar flexion	Mild impairment; Pain only at end ranges of active lumbar flexion	No impairment; No pain with active lumbar flexion
Flexibility / Muscle length (hip extension / Iliacus) Iliacus flexibility	Moderate extension flexibility deficits: -10° to 0°	Moderate extension flexibility deficits: ~10° to 0°	Normal extension flexibility: > 10° of hip extension
Flexibility / Muscle length (hamstring / straight leg raise) Hamstring flexibility assessed using the straight leg raising test	Moderate straight leg raise flexibility deficits: 40° to 49°	Moderate straight leg raise flexibility deficits: 40° to 49°	Normal straight leg raise flexibility: > 60°
Strength (lumbar extensors) Lumbar extensors muscle test grade	Moderate weakness; 3/5 strength	Moderate weakness; 3/5 strength	Normal; 5/5 strength
Oswestry Low Back Pain Disability Index (ODI) Score on the Modified Oswestry Low Back Disability Index (ODI)	Severe activity limitation; ODI score 41 to 80	Moderate activity limitation; ODI score 21 to 40	No activity limitation; ODI score 0 to 4

Additional Evaluative Findings

patient had no complaints of numbness/tingling into the bilateral lower extremities.

Treatment Provided Today

The following interventions were performed for the patient's lumbar spine condition:

Massage Therapy (97124):

Cold Laser (97039):

Infrared / Anodyne (97026):

Provider Interactions With Patient During Visit

Verbal cuing on proper performance of the movement.

Verbal cuing on joint protection measures.

Assessment

The examination of [REDACTED] Identified low back mobility deficits associated with a current post-operative condition. Physical therapy intervention strategies designed to address these impairments will be instrumental in achieving the stated functional goals, including her ability to perform walking tasks. The additional presence of chronic pain in the involved region will likely impact the frequency of physical therapy interventions and will be addressed throughout the episode of care. Based on the examination, the patient's rehabilitation potential to achieve functional goals is excellent.

Functional Goal	Patient Progress
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Low back pain will improve to be able to bend below the waist and lift 10lbs intermittently for 4 hours daily for occupational activities; Timeframe: 16 weeks.	The patient reports a reduction in symptoms and improvement in function of more than 50% since initiating therapy. Achieving the patient's goals with continued therapy is expected.
Pelvic girdle pain and strength will improve to be able to weight shift with prolonged standing and walking for 2 hours daily for occupational activities; Timeframe: 16 weeks.	The patient reports a reduction in symptoms and improvement in function of more than 50% since initiating therapy. Achieving the patient's goals with continued therapy is expected.

Plan

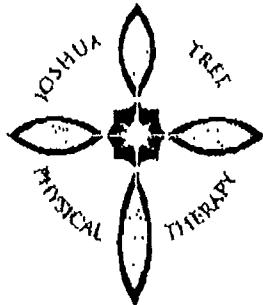
At the next visit, the preferred treatment order is: 1. Modellier, 2. Activities and Exercises, 3. Manual Therapy.

Treatment Time

20 minutes direct contact (timed) with patient.
50 minutes total treatment time.

Therapist Signature(s)

Chronically signed by Kevin J Sgroi PT on 1/22/2011 16:11:16 PST



Treatment Note

Joshua Tree Physical Therapy
Hayden
8475 N. Government Way
Suite 102
Hayden, ID 83835
tel: (208) 772-9774
fax: (208) 772-9564

Patient: [REDACTED]
Gender: F
DOB: [REDACTED]

Injury Date: 10/15/2010
Evaluation Date: 03/10/2011
Visit #: 11/08/2011

Therapist of Record: Kevin J Sgroi PT
Referring Practitioner: Ronda Westcott MD

Provider: Kevin J Sgroi PT
Provider Email: kevin@joshuatreept.com

#	Medical Diagnoses	ICD-9
1)	Lumbago (Back Pain)	724.2

#	Treating Diagnoses	ICD-9
1)	Lumbar segmental dysfunction	739.3
2)	Lumbar sprain and strain	847.2
3)	Muscle spasm	728.05
4)	Musculoskeletal surgical aftercare	V58.78

Patient Status

Patient stated that when she bends forward or low back hurts. Patient also complains of headaches on occasion however, unsure frequency.

Measures

The following measures were identified for the patient's Lumbar Spine condition:

Measure	Initial (03/10/2011)	Current (11/08/2011)	Target
Standing weight-shift (symptoms) Shifting weight from one leg to the other while standing without symptoms	Severe difficulty: 50 % weight bearing on 1 leg produces symptoms	Severe difficulty: 50 % weight bearing on 1 leg produces symptoms	No difficulty: Bears full weight on 1 leg without symptoms
Sitting (capacity) Ability to sit	Severe difficulty: Only able to sit < 1 hour/day	Severe difficulty: Only able to sit < 1 hour/day	No difficulty: Sitting capability is unlimited
Standing (capacity) Ability to stand	Severe difficulty: Only able to stand < 1 hour/day	Severe difficulty: Only able to stand < 1 hour/day	No difficulty: Standing capability is unlimited
Walking medium distances (symptoms) Walking medium distances without symptoms	Severe problem: Only able to walk < 100 yards without symptoms	Severe problem: Only able to walk < 100 yards without symptoms	No problem: Able to walk > 1000 yards without symptoms
Pain (at rest) Current level of pain	Mild pain: 1/10 to 2/10	Mild pain: 1/10 to 2/10	No pain: 0/10
Pain (at worst) Highest level of pain during the last 24 hours	Severe pain: 6/10 to 9/10	Moderate pain: 3/10 to 5/10	No pain: 0/10
Pain (with movement) Highest level of pain while performing the most aggravating movement	Severe pain: 6/10 to 9/10	Mild pain: 1/10 to 2/10	No pain: 0/10

Measure	Initial (03/10/2011)	Current (11/08/2011)	Target
AROM / Pain (lumbar extension) Movement / pain relations with active lumbar extension	Severe impairment: Pain during initial ranges of active lumbar extension	Severe impairment: Pain during initial ranges of active lumbar extension	No impairment: No pain with active lumbar extension
AROM / Pain (lumbar flexion) Movement / pain relations with active lumbar flexion	Mild impairment: Pain only at end ranges of active lumbar flexion	Mild impairment: Pain only at end ranges of active lumbar flexion	No impairment: No pain with active lumbar flexion
Flexibility / Muscle length (hip extension / iliacus) Iliacus flexibility	Moderate extension flexibility deficits: -10° to 0°	Moderate extension flexibility deficits: -10° to 0°	Normal extension flexibility: > 10° of hip extension
Flexibility / Muscle length (hamstring / straight leg raise) Hamstring flexibility assessed using the straight leg raising test	Moderate straight leg raise flexibility deficits: 40° to 49°	Moderate straight leg raise flexibility deficits: 40° to 49°	Normal straight leg raise flexibility: > 80°
Strength (lumbar extensors) Lumbar extensors muscle test grade	Moderate weakness; 3/6 strength	Moderate weakness; 3/5 strength	Normal: 5/5 strength
Oswestry Low Back Pain Disability Index (ODI) Score on the Modified Oswestry Low Back Disability Index (ODI)	Severe activity limitation: ODI score 41 to 80	Moderate activity limitation: ODI score 21 to 40	No activity limitation: ODI score 0 to 4

Additional Evaluative Findings

patient had no complaints of numbness/tingling into the bilateral lower extremities.

Treatment Provided Today

The following interventions were performed for the patient's lumbar spine condition:

Massage Therapy (97124):

Cold Laser (97039):

Infrared / Anodyne (97020):

Provider Interactions With Patient During Visit

Verbal cuing on joint protection measures.

Assessment

The examination of [REDACTED] identified low back mobility deficits associated with a current post-operative condition. Physical therapy intervention strategies designed to address these impairments will be instrumental in achieving the stated functional goals, including her ability to perform walking tasks. The additional presence of chronic pain in the involved region will likely impact the frequency of physical therapy interventions and will be addressed throughout the episode of care. Based on the examination, the patient's rehabilitation potential to achieve functional goals is excellent.

Functional Goal	Patient Progress
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Low back pain will improve to be able to bend below the waist and lift 10lbs intermittently for 4 hours daily for occupational activities; Timeframe: 16 weeks.

The patient reports a reduction in symptoms and improvement in function of more than 50% since initiating therapy. Achieving the patient's goals with continued therapy is expected.

Pelvic girdle pain and strength will improve to be able to weight shift with prolonged standing and walking for 2 hours daily for occupational activities; Timeframe: 16 weeks.

The patient reports a reduction in symptoms and improvement in function of more than 40 % since initiating therapy. Achieving the patient's goals with continued therapy is expected.

Plan

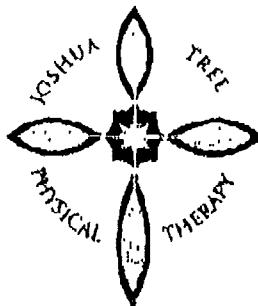
At the next visit, the preferred treatment order is: 1. Modalities, 2. Activities and Exercises, 3. Manual Therapy.

Treatment Time

20 minutes direct contact (timed) with patient.
50 minutes total treatment time.

Therapist Signature(s)

Electronically signed by Kevin J Sgouf on 11/08/2011 12:11:14 PST



Treatment Note

Joshua Tree Physical Therapy
Hayden
8475 N. Government Way
Suite 102
Hayden, ID 83835
tel: (208) 772-9774
fax: (208) 772-9564

Patient: [REDACTED]
Gender: F
DOB: [REDACTED]

Injury Date: 10/15/2010
Evaluation Date: 03/10/2011
Visit #7: 11/03/2011

Therapist of Record: Kevin J Sgrol PT
Referring Practitioner: Ronda Westcott MD

Provider: Kevin J Sgrol PT
Provider Email: kevin@joshuatreept.com

# Medical Diagnoses	ICD-9
1) Lumboago (Back Pain)	724.2

# Treating Diagnoses	ICD-9
1) Lumbar segmental dysfunction	739.3
2) Lumbar sprain and strain	847.2
3) Muscle spasm	728.85
4) Musculoskeletal surgical aftercare	V58.78

Patient Status

Patient stated that when she bends forward or low back hurts. Patient also complains of headaches on occasion however, unsure frequency.

Measures

The following measures were identified for the patient's Lumbar Spine condition:

Measure	Initial (03/10/2011)	Current (11/03/2011)	Target
Standing weight-shift (symptoms) Shifting weight from one leg to the other while standing without symptoms	Severe difficulty: 50 % weight bearing on 1 leg produces symptoms	Severe difficulty: 50 % weight bearing on 1 leg produces symptoms	No difficulty: Bears full weight on 1 leg without symptoms
Sitting (capacity) Ability to sit	Severe difficulty: Only able to sit < 1 hour/day	Severe difficulty: Only able to sit < 1 hour/day	No difficulty: Sitting capacity is unlimited
Standing (capacity) Ability to stand	Severe difficulty: Only able to stand < 1 hour/day	Severe difficulty: Only able to stand < 1 hour/day	No difficulty: Standing capacity is unlimited
Walking medium distances (symptoms) Walking medium distances without symptoms	Severe problem: Only able to walk < 100 yards without symptoms	Severe problem: Only able to walk < 100 yards without symptoms	No problem: Able to walk > 1000 yards without symptoms
Pain (at rest) Current level of pain	Mild pain: 1/10 to 2/10	Mild pain: 1/10 to 2/10	No pain: 0/10
Pain (at worst) Highest level of pain during the last 24 hours	Severe pain: 6/10 to 9/10	Moderate pain: 3/10 to 5/10	No pain: 0/10
Pain (with movement) Highest level of pain while performing the most aggravating movement	Severe pain: 6/10 to 9/10	Mild pain: 1/10 to 2/10	No pain: 0/10

Measure	Initial (03/10/2011)	Current (03/10/2011)	Target
AROM / Pain (lumbar extension) Movement / pain relations with active lumbar extension	Severe impairment: Pain during initial ranges of active lumbar extension	Severe Impairment: Pain during initial ranges of active lumbar extension	No impairment: No pain with active lumbar extension
AROM / Pain (lumbar flexion) Movement / pain relations with active lumbar flexion	Mild impairment: Pain only at end ranges of active lumbar flexion	Mild impairment: Pain only at end ranges of active lumbar flexion	No impairment: No pain with active lumbar flexion
Flexibility / Muscle length (hip extension / Iliacus) Iliacus flexibility	Moderate extension flexibility deficits: -10° to 0°	Moderate extension flexibility deficits: -10° to 0°	Normal extension flexibility: > 10° of hip extension
Flexibility / Muscle length (hamstring / straight leg raise) Hamstring flexibility assessed using the straight leg raising test	Moderate straight leg raise flexibility deficits: 40° to 49°	Moderate straight leg raise flexibility deficits: 40° to 49°	Normal straight leg raise flexibility: > 60°
Strength (lumbar extensors) Lumbar extensors muscle test grade	Moderate weakness: 3/5 strength	Moderate weakness: 3/5 strength	Normal: 5/5 strength
Oswestry Low Back Pain Disability Index (ODI) Score on the Modified Oswestry Low Back Disability Index (ODI)	Severe activity limitation: ODI score 41 to 80	Moderate activity limitation: ODI score 21 to 40	No activity limitation: ODI score 0 to 4

Additional Evaluative Findings

patient had no complaints of numbness/tingling into the bilateral lower extremities.

Treatment Provided Today

The following interventions were performed for the patient's lumbar spine condition:

Massage Therapy (97124):

Cold Laser (97039):

Infrared / Anodyne (97026):

Provider Interactions With Patient During Visit

Assessment

The examination of [REDACTED] identified low back mobility deficits associated with a current post-operative condition. Physical therapy intervention strategies designed to address these impairments will be instrumental in achieving the stated functional goals, including her ability to perform walking tasks. The additional presence of chronic pain in the involved region will likely impact the frequency of physical therapy interventions and will be addressed throughout the episode of care. Based on the examination, the patient's rehabilitation potential to achieve functional goals is excellent.

Functional Goal	Patient Progress
Low back pain will improve to be able to bend below the waist and lift 10lbs intermittently for 4 hours daily for occupational activities; Timeframe: 16 weeks.	The patient reports a reduction in symptoms and improvement in function of more than 40% since initiating therapy. Achieving the patient's goals with continued therapy is expected.

Pelvic girdle pain and strength will improve to be able to weight shift with prolonged standing and walking for 2 hours daily for occupational activities; Timeframe: 16 weeks.

The patient reports a reduction in symptoms and improvement in function of more than 40 % since initiating therapy. Achieving the patient's goals with continued therapy is expected.

Plan

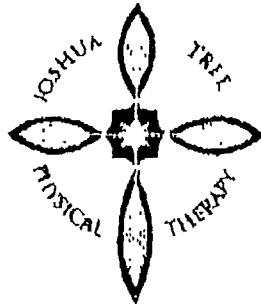
At the next visit, the preferred treatment order is: 1. Modalities, 2. Activities and Exercises, 3. Manual Therapy.

Treatment Time

20 minutes direct contact (timed) with patient.
60 minutes total treatment time.

Therapist Signature(s)

Electronically signed by Karen J. Sigmund PT on 11/04/2011 17:11:08 PDT



Treatment Note

Joshua Tree Physical Therapy
Hayden
8475 N. Government Way
Suite 102
Hayden, ID 83835
tel: (208) 772-9774
fax: (208) 772-9564

Patient: [REDACTED]
Gender: F
DOB: [REDACTED]

Injury Date: 10/16/2010
Evaluation Date: 03/10/2011
Visit #61 10/13/2011

Therapist of Record: Kevin J Sgroi PT
Referring Practitioner: Ronda Westcott MD

Provider: Kevin J Sgroi PT
Provider Email: kevin@joshuatreept.com

# Medical Diagnoses	ICD-9	# Treating Diagnoses	ICD-9
1) Lumbago (Back Pain)	724.2	1) Lumbar segmental dysfunction 2) Lumbar sprain and strain 3) Muscle spasm 4) Musculoskeletal surgical aftercare	739.3 847.2 728.86 V58.78

Patient Status

Patient complain of increased low back pain when she bends over. She also complained of her legs becoming tired when she plays.

Measures

The following measures were identified for the patient's Lumbar Spine condition:

Measure	Initial (03/10/2011)	Current (10/13/2011)	Target
Standing weight-shift (symptome) Shifting weight from one leg to the other while standing without symptoms	Severe difficulty: 50 % weight bearing on 1 leg produces symptoms	Severe difficulty: 50 % weight bearing on 1 leg produces symptoms	No difficulty: Bears full weight on 1 leg without symptoms
Sitting (capacity) Ability to sit	Severe difficulty: Only able to sit < 1 hour/day	Severe difficulty: Only able to sit < 1 hour/day	No difficulty: Sitting capability is unlimited
Standing (capacity) Ability to stand	Severe difficulty: Only able to stand < 1 hour/day	Severe difficulty: Only able to stand < 1 hour/day	No difficulty: Standing capability is unlimited
Walking medium distances (symptome) Walking medium distances without symptoms	Severe problem: Only able to walk < 100 yards without symptoms	Severe problem: Only able to walk < 100 yards without symptoms	No problem: Able to walk > 1000 yards without symptoms
Pain (at rest) Current level of pain	Mild pain: 1/10 to 2/10	Mild pain: 1/10 to 2/10	No pain: 0/10
Pain (at worst) Highest level of pain during the last 24 hours	Severe pain: 8/10 to 9/10	Moderate pain: 3/10 to 5/10	No pain: 0/10
Pain (with movement) Highest level of pain while performing the most aggravating movement	Severe pain: 8/10 to 9/10	Moderate pain: 3/10 to 5/10	No pain: 0/10

Measure	Initial (10/10/2011)	Current (10/13/2011)	Target
AROM / Pain (lumbar extension) Movement / pain relations with active lumbar extension	Severe impairment: Pain during initial ranges of active lumbar extension	Severe impairment: Pain during initial ranges of active lumbar extension	<i>No impairment: No pain with active lumbar extension</i>
AROM / Pain (lumbar flexion) Movement / pain relations with active lumbar flexion	Mild impairment: Pain only at end ranges of active lumbar flexion	Mild impairment: Pain only at end ranges of active lumbar flexion	<i>No impairment: No pain with active lumbar flexion</i>
Flexibility / Muscle length (hip extension / iliacus) iliacus flexibility	Moderate extension flexibility deficits: -10° to 0°	Moderate extension flexibility deficits: -10° to 0°	<i>Normal extension flexibility: > 10° of hip extension</i>
Flexibility / Muscle length (hamstring / straight leg raise) Hamstring flexibility assessed using the straight leg raising test	Moderate straight leg raise flexibility deficits: 40° to 49°	Moderate straight leg raise flexibility deficits: 40° to 49°	<i>Normal straight leg raise flexibility: > 60°</i>
Strength (lumbar extensors) Lumbar extensors muscle test grade	Moderate weakness: 3/5 strength	Moderate weakness: 3/5 strength	<i>Normal: 5/5 strength</i>
Oswestry Low Back Pain Disability Index (ODI) Score on the Modified Oswestry Low Back Disability Index (ODI)	Severe activity limitation: ODI score 41 to 80	Moderate activity limitation: ODI score 21 to 40	<i>No activity limitation: ODI score 0 to 4</i>

Additional Evaluative Findings

patient stated that she had no complaints of headaches today.

Treatment Provided Today

The following interventions were performed for the patient's lumbar spine condition:

Massage Therapy (97124):

Cold Laser (97030):

Infrared / Anodyne (97026):

Provider Interactions With Patient During Visit

Verbal cueing on proper performance of the movement.

Verbal cueing on joint protection measures.

Assessment

The examination of [REDACTED] identified low back mobility deficits associated with a current post-operative condition. Physical therapy intervention strategies designed to address these impairments will be instrumental in achieving the stated functional goals, including her ability to perform walking tasks. The additional presence of chronic pain in the involved region will likely impact the frequency of physical therapy interventions and will be addressed throughout the episode of care. Based on the examination, the patient's rehabilitation potential to achieve functional goals is excellent.

Functional Goal

Patient Progress

Low back pain will improve to be able to bend below the waist and lift 10lbs intermittently for 4 hours daily for occupational activities; Timeframe: 16 weeks.	The patient reports a reduction in symptoms and improvement in function of more than 35% since initiating therapy. Achieving the patient's goals with continued therapy is expected.
Pelvic girdle pain and strength will improve to be able to weight shift with prolonged standing and walking for 2 hours daily for occupational activities; Timeframe: 16 weeks.	The patient reports a reduction in symptoms and improvement in function of more than 30 % since initiating therapy. Achieving the patient's goals with continued therapy is expected.

Plan

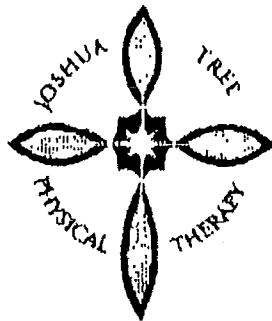
At the next visit, the preferred treatment order is: 1. Modalities, 2. Activities and Exercises, 3. Manual Therapy.

Treatment Time

20 minutes direct contact (timed) with patient,
50 minutes total treatment time.

Therapist Signature(s)

Electronically signed by Kevin J Sprol PT on 10/13/2011 12:10:57 PDT



Treatment Note

Joshua Tree Physical Therapy
 Hayden
 8475 N. Government Way
 Suite 102
 Hayden, ID 83835
 tel: (208) 772-9774
 fax: (208) 772-9564

Patient: [REDACTED]
 Gender: F
 DOB: [REDACTED]

Injury Date: 10/16/2010
 Evaluation Date: 03/10/2011
 Visit #6: 09/29/2011

Therapist of Record: Kevin J Sgrol PT
 Referring Practitioner: Ronda Westcott MD

Provider: Kevin J Sgrol PT
 Provider Email: kevin@joshuatreept.com

#	Medical Diagnoses	ICD-9
1)	Lumbago (Back Pain)	724.2

#	Treating Diagnoses	ICD-9
1)	Lumbar segmental dysfunction	730.3
2)	Lumbar sprain and strain	847.2
3)	Muscle spasm	728.85
4)	Musculoskeletal surgical aftercare	V68.78

Patient Status

[REDACTED] reports that, overall her condition improved as evidenced by her greater ability to sleep.

Measures

The following measures were identified for the patient's Lumbar Spine condition:

Measure	Initial (03/10/2011)	Current (09/29/2011)	Target
Standing weight-shift (symptoms) Shifting weight from one leg to the other while standing without symptoms	Severe difficulty: 50 % weight bearing on 1 leg produces symptoms	Severe difficulty: 50 % weight bearing on 1 leg produces symptoms	No difficulty: Bears full weight on 1 leg without symptoms
Sitting (capacity) Ability to sit	Severe difficulty: Only able to sit < 1 hour/day	Severe difficulty: Only able to sit < 1 hour/day	No difficulty: Sitting capability is unlimited
Standing (capacity) Ability to stand	Severe difficulty: Only able to stand < 1 hour/day	Severe difficulty: Only able to stand < 1 hour/day	No difficulty: Standing capability is unlimited
Walking medium distances (symptoms) Walking medium distances without symptoms	Severe problem: Only able to walk < 100 yards without symptoms	Severe problem: Only able to walk < 100 yards without symptoms	No problem: Able to walk > 1000 yards without symptoms
Pain (at rest) Current level of pain	Mild pain: 1/10 to 2/10	Mild pain: 1/10 to 2/10	No pain: 0/10
Pain (at worst) Highest level of pain during the last 24 hours	Severe pain: 6/10 to 9/10	Moderate pain: 3/10 to 5/10	No pain: 0/10
Pain (with movement) Highest level of pain while performing the most aggravating movement	Severe pain: 6/10 to 9/10	Severe pain: 6/10 to 9/10	No pain: 0/10

Measure	Initial (08/02/2011)	Current (09/29/2011)	Target
AROM / Pain (lumbar extension) Movement / pain relations with active lumbar extension	Severe impairment: Pain during initial ranges of active lumbar extension	Severe impairment: Pain during initial ranges of active lumbar extension	<i>No impairment: No pain with active lumbar extension</i>
AROM / Pain (lumbar flexion) Movement / pain relations with active lumbar flexion	Mild impairment: Pain only at end ranges of active lumbar flexion	Mild impairment: Pain only at end ranges of active lumbar flexion	<i>No impairment: No pain with active lumbar flexion</i>
Flexibility / Muscle length (hip extension / Iliacus) Iliacus flexibility	Moderate extension flexibility deficits: -10° to 0°	Moderate extension flexibility deficits: -10° to 0°	<i>Normal extension flexibility: > 10° of hip extension</i>
Flexibility / Muscle length (hamstring / straight leg raise) Hamstring flexibility assessed using the straight leg raising test	Moderate straight leg raise flexibility deficits: 40° to 49°	Moderate straight leg raise flexibility deficits: 40° to 49°	<i>Normal straight leg raise flexibility: > 60°</i>
Strength (lumbar extensors) Lumbar extensors muscle test grade	Moderate weakness: 3/5 strength	Moderate weakness: 3/5 strength	<i>Normal: 5/5 strength</i>
Oswestry Low Back Pain Disability Index (ODI) Score on the Modified Oswestry Low Back Disability Index (ODI)	Severe activity limitation: ODI score 41 to 80	Moderate activity limitation: ODI score 21 to 40	<i>No activity limitation: ODI score 0 to 4</i>

Additional Evaluative Findings

patient stated that she had no complaints of headaches today.

Treatment Provided Today

The following interventions were performed for the patient's lumbar spine condition:

Massage Therapy (97124):

Cold Laser (97039):

Infrared / Anodyne (97026):

Provider Interactions With Patient During Visit

Verbal cuing on proper performance of the movement.

Verbal cuing on joint protection measures.

Assessment

The examination of [REDACTED] identified low back mobility deficits associated with a current post-operative condition. Physical therapy intervention strategies designed to address these impairments will be instrumental in achieving the stated functional goals, including her ability to perform walking tasks. The additional presence of chronic pain in the involved region will likely impact the frequency of physical therapy interventions and will be addressed throughout the episode of care. Based on the examination, the patient's rehabilitation potential to achieve functional goals is excellent.

Functional Goal	Patient Progress
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Low back pain will improve to be able to bend below the waist and lift 10lbs intermittently for 4 hours daily for occupational activities; Timeframe: 16 weeks.	The patient reports a reduction in symptoms and improvement in function of more than 35% since initiating therapy. Achieving the patient's goals with continued therapy is expected.
Pelvic girdle pain and strength will improve to be able to weight shift with prolonged standing and walking for 2 hours daily for occupational activities; Timeframe: 16 weeks.	The patient reports a reduction in symptoms and improvement in function of more than 30 % since initiating therapy. Achieving the patient's goals with continued therapy is expected.

Plan

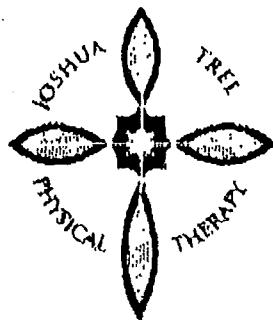
At the next visit, the preferred treatment order is; 1. Modalities, 2. Activities and Exercises, 3. Manual Therapy.

Treatment Time

20 minutes direct contact (timed) with patient.
50 minutes total treatment time.

Therapist Signature(s)

Electronically signed by Kevin J. Sgemi PT on 09/20/2011 17:00:34 PDT



Treatment Note

Joshua Tree Physical Therapy
 Hayden
 8475 N. Government Way
 Suite 102
 Hayden, ID 83835
 tel: (208) 772-9774
 fax: (208) 772-9564

Patient: [REDACTED]
 Gender: F
 DOB: [REDACTED]

Injury Date: 10/15/2010
 Evaluation Date: 03/10/2011
 Visit #4: 09/20/2011

Therapist of Record: Kevin J Sgroi PT
 Referring Practitioner: Ronda Weetcott MD

Provider: Kevin J Sgroi PT
 Provider Email: kevin@joshuatreeapt.com

#	Medical Diagnoses	ICD-9
1)	Lumbago (Back Pain)	724.2

#	Treating Diagnoses	ICD-9
1)	Lumbar segmental dysfunction	739.3
2)	Lumbar sprain and strain	847.2
3)	Muscle spasm	728.85
4)	Musculoskeletal surgical aftercare	V58.70

Patient Status

[REDACTED] reports that, overall her condition improved as evidenced by her greater ability to sleep.

Measures

The following measures were identified for the patient's Lumbar Spine condition:

Measure	Initial (02/01/2011)	Current (09/20/2011)	Target
Standing weight-shift (symptoms) Shifting weight from one leg to the other while standing without symptoms	Severe difficulty: 50 % weight bearing on 1 leg produces symptoms	Severe difficulty: 50 % weight bearing on 1 leg produces symptoms	No difficulty: Bears full weight on 1 leg without symptoms
Sitting (capacity) Ability to sit	Severe difficulty: Only able to sit < 1 hour/day	Severe difficulty: Only able to sit < 1 hour/day	No difficulty: Sitting capability is unlimited
Standing (capacity) Ability to stand	Severe difficulty: Only able to stand < 1 hour/day	Severe difficulty: Only able to stand < 1 hour/day	No difficulty: Standing capability is unlimited
Walking medium distances (symptoms) Walking medium distances without symptoms	Severe problem: Only able to walk < 100 yards without symptoms	Severe problem: Only able to walk < 100 yards without symptoms	No problem: Able to walk > 1000 yards without symptoms
Pain (at rest) Current level of pain	Mild pain: 1/10 to 2/10	Mild pain: 1/10 to 2/10	No pain: 0/10
Pain (at worst) Highest level of pain during the last 24 hours	Severe pain: 6/10 to 9/10	Moderate pain: 3/10 to 5/10	No pain: 0/10
Pain (with movement) Highest level of pain while performing the most aggravating movement	Severe pain: 6/10 to 9/10	Severe pain: 6/10 to 9/10	No pain: 0/10

Measure	Initial (7/17/2012)	Current (9/20/2012)	Target
AROM / Pain (lumbar extension) Movement / pain relations with active lumbar extension	Severe impairment: Pain during initial ranges of active lumbar extension	Severe impairment: Pain during initial ranges of active lumbar extension	<i>No impairment: No pain with active lumbar extension</i>
AROM / Pain (lumbar flexion) Movement / pain relations with active lumbar flexion	Mild impairment: Pain only at end ranges of active lumbar flexion	Mild impairment: Pain only at end ranges of active lumbar flexion	<i>No impairment: No pain with active lumbar flexion</i>
Flexibility / Muscle length (hip extension / Iliacus) Iliacus flexibility	Moderate extension flexibility deficits: -10° to 0°	Moderate extension flexibility deficits: -10° to 0°	<i>Normal extension flexibility: > 10° of hip extension</i>
Flexibility / Muscle length (hamstring / straight leg raise) Hamstring flexibility assessed using the straight leg raising test	Moderate straight leg raise flexibility deficits: 40° to 49°	Moderate straight leg raise flexibility deficits: 40° to 49°	<i>Normal straight leg raise flexibility: > 60°</i>
Strength (lumbar extensors) Lumbar extensors muscle test grade	Moderate weakness: 3/5 strength	Moderate weakness: 3/5 strength	<i>Normal: 5/5 strength</i>
Oswestry Low Back Pain Disability Index (ODI) Score on the Modified Oswestry Low Back Disability Index (ODI)	Severe activity limitation: ODI score 41 to 80	Moderate activity limitation: ODI score 21 to 40	<i>No activity limitation: ODI score 0 to 4</i>

Additional Evaluative Findings

Patient complained of increased cervical spine pain and headaches since last treatment.

Treatment Provided Today

The following interventions were performed for the patient's lumbar spine condition:

Massage Therapy (97124):

Cold Laser (97039):

Infrared / Anodyne (97026):

Provider Interactions With Patient During Visit

Verbal cuing on proper performance of the movement.

Assessment

The examination of [REDACTED] identified low back mobility deficits associated with a current post-operative condition. Physical therapy intervention strategies designed to address these impairments will be instrumental in achieving the stated functional goals, including her ability to perform walking tasks. The additional presence of chronic pain in the involved region will likely impact the frequency of physical therapy interventions and will be addressed throughout the episode of care. Based on the examination, the patient's rehabilitation potential to achieve functional goals is excellent.

Functional Goal	Patient Progress

Low back pain will improve to be able to bend below the waist and lift 10lbs intermittently for 4 hours daily for occupational activities; Timeframe: 16 weeks.	The patient reports a reduction in symptoms and improvement in function of more than 35% since initiating therapy. Achieving the patient's goals with continued therapy is expected.
Pelvic girdle pain and strength will improve to be able to weight shift with prolonged standing and walking for 2 hours daily for occupational activities; Timeframe: 16 weeks.	The patient reports a reduction in symptoms and improvement in function of more than 30 % since initiating therapy. Achieving the patient's goals with continued therapy is expected.

Plan

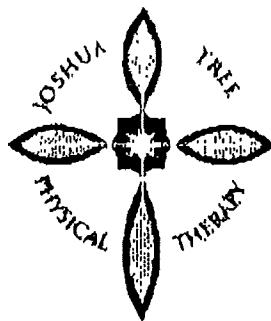
At the next visit, the preferred treatment order is: 1. Modalities, 2. Activities and Exercises, 3. Manual Therapy.

Treatment Time

20 minutes direct contact (timed) with patient,
60 minutes total treatment time.

Therapist Signature(s)

Electronically signed by Kevin J Sgori PT on 09/20/2011 12:09:41 PDT



Treatment Note

Joshua Tree Physical Therapy
Hayden
8475 N, Government Way
Suite 102
Hayden, ID 83836
tel: (208) 772-9774
fax: (208) 772-9564

Patient: [REDACTED]
Gender: F
DOB: [REDACTED]

Injury Date: 10/15/2010
Evaluation Date: 03/10/2011
Visit #3: 08/29/2011

Therapist of Record: Kevin J Sgrol PT
Referring Practitioner: Ronde Westcott MD

Provider: Kevin J Sgrol PT
Provider Email: kevin@joshuatreept.com

Medical Diagnoses

ICD-9

1) Lumbago (Back Pain)

724.2

Treating Diagnoses

ICD-9

1) Lumbar segmental dysfunction	739.3
2) Lumbar sprain and strain	847.2
3) Muscle spasm	728.85
4) Musculoskeletal surgical aftercare	V58.78

Patient Status

[REDACTED] reports that, overall her condition improved as evidenced by her greater ability to sleep.

Measures

The following measures were identified for the patient's Lumbar Spine condition:

Measure	Initial (03/10/2011)	Current (08/29/2011)	Target
Standing weight-shift (symptoms) Shifting weight from one leg to the other while standing without symptoms	Severe difficulty: 50 % weight bearing on 1 leg produces symptoms	Severe difficulty: 50 % weight bearing on 1 leg produces symptoms	No difficulty: Bears full weight on 1 leg without symptoms
Sitting (capacity) Ability to sit	Severe difficulty: Only able to sit < 1 hour/day	Severe difficulty: Only able to sit < 1 hour/day	No difficulty: Sitting capability is unlimited
Standing (capacity) Ability to stand	Severe difficulty: Only able to stand < 1 hour/day	Severe difficulty: Only able to stand < 1 hour/day	No difficulty: Standing capability is unlimited
Walking medium distances (symptoms) Walking medium distances without symptoms	Severe problem: Only able to walk < 100 yards without symptoms	Severe problem: Only able to walk < 100 yards without symptoms	No problem: Able to walk > 1000 yards without symptoms
Pain (at rest) Current level of pain	Mild pain: 1/10 to 2/10	Mild pain: 1/10 to 2/10	No pain: 0/10
Pain (at worst) Highest level of pain during the last 24 hours	Severe pain: 6/10 to 9/10	Severe pain: 6/10 to 9/10	No pain: 0/10
Pain (with movement) Highest level of pain while performing the most aggravating movement	Severe pain: 6/10 to 9/10	Severe pain: 6/10 to 9/10	No pain: 0/10

Measure	Initial (08/11/2011)	Current (08/09/2011)	Target
AROM / Pain (lumbar extension) Movement / pain relations with active lumbar extension	Severe impairment: Pain during initial ranges of active lumbar extension	Severe impairment: Pain during initial ranges of active lumbar extension	No impairment: No pain with active lumbar extension
AROM / Pain (lumbar flexion) Movement / pain relations with active lumbar flexion	Mild impairment: Pain only at end ranges of active lumbar flexion	Mild Impairment: Pain only at end ranges of active lumbar flexion	No impairment: No pain with active lumbar flexion
Flexibility / Muscle length (hip extension / Iliacus) Iliacus flexibility	Moderate extension flexibility deficit: -10° to 0°	Moderate extension flexibility deficit: -10° to 0°	Normal extension flexibility: > 10° of hip extension
Flexibility / Muscle length (hamstring / straight leg raise) Hamstring flexibility assessed using the straight leg raising test	Moderate straight leg raise flexibility deficit: 40° to 49°	Moderate straight leg raise flexibility deficit: 40° to 49°	Normal straight leg raise flexibility: > 60°
Strength (lumbar extensors) Lumbar extensors muscle test grade	Moderate weakness: 3/5 strength	Moderate weakness: 3/5 strength	Normal: 5/5 strength
Oswestry Low Back Pain Disability Index (ODI) Score on the Modified Oswestry Low Back Disability Index (ODI)	Severe activity limitation; ODI score 41 to 80	Moderate activity limitation; ODI score 21 to 40	No activity limitation; ODI score 0 to 4

Additional Evaluative Findings

patient has moderate to severe tonic muscle spasms throughout the cervical spine and lumbar.

Treatment Provided Today

The following interventions were performed for the patient's lumbar spine condition:

Massage Therapy (97124):

Cold Laser (97039):

Infrared / Anodyne (97020):

Provider Interactions With Patient During Visit

Verbal cueing on proper performance of the movement.

Assessment

The examination of [REDACTED] identified low back mobility deficits associated with a current post-operative condition. Physical therapy intervention strategies designed to address these impairments will be instrumental in achieving the stated functional goals, including her ability to perform walking tasks. The additional presence of chronic pain in the involved region will likely impact the frequency of physical therapy interventions and will be addressed throughout the episode of care. Based on the examination, the patient's rehabilitation potential to achieve functional goals is excellent.

Functional Goal	Patient Progress
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Low back pain will improve to be able to bend below the waist and lift 10lbs intermittently for 4 hours daily for occupational activities; Timeframe: 16 weeks.	The patient reports a reduction in symptoms and improvement in function of more than 25 % since initiating therapy. Achieving the patient's goals with continued therapy is expected.
Pelvic girdle pain and strength will improve to be able to weight shift with prolonged standing and walking for 2 hours daily for occupational activities; Timeframe: 16 weeks.	The patient reports a reduction in symptoms and improvement in function of more than 25 % since initiating therapy. Achieving the patient's goals with continued therapy is expected.

Plan

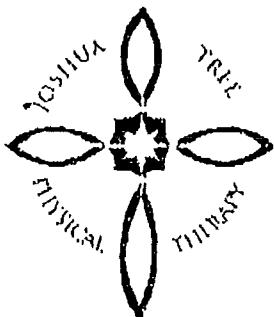
At the next visit, the preferred treatment order is: 1. Modalities, 2. Activities and Exercises, 3. Manual Therapy.

Treatment Time

20 minutes direct contact (timed) with patient.
60 minutes total treatment time.

Therapist Signature(s)

Electronically signed by Kevin J Sgroi PT on 08/29/2011 15:08:36 PDT



Initial Evaluation

Joshua Tree Physical Therapy
Hayden
8475 N. Government Way
Suite 102
Hayden, ID 83835
tel: (208) 772-9774
fax: (208) 772-9664

Patient: [REDACTED]
Gender: F
DOB: [REDACTED]

Injury Date: 10/15/2010
Evaluation Date: 03/10/2011
Visit #1: 03/10/2011

Therapist of Record:
Referring Practitioner: Ronda Westcott MD

Provider: Kevin J Sgroi PT
Provider Email: kevin@joshuatreept.com

#	Medical Diagnoses	ICD-9
1)	Lumbago (Back Pain)	724.2

#	Treating Diagnoses	ICD-9
1)	Lumbar segmental dysfunction	739.3
2)	Lumbar sprain and strain	847.2
3)	Muscle spasm	728.85
4)	Musculoskeletal surgical aftercare	V58.78

Reason For Referral

[REDACTED] is a [REDACTED] year-old female, who reports a history of gradually increasing low back pain, that began approximately in June of 2009 and was associated with surgical intervention for spinal cord abnormality: Arnold Chiari disease. She has now been referred to physical therapy to begin postoperative rehabilitation. Ms. Bryant is an otherwise healthy female without any prior medical complications that would limit her full and active participation in rehabilitation.

Medical History

Fall History: Patient has not been injured by a fall in the past year. Patient has not had two or more falls in the past year.

Clinical Findings

1. **Lumbar Spine:**
Pain location - low back, buttock or posterior thigh (unilateral): yes
Pain location - low back, thigh, calf, ankle or foot: yes
Paresthesia location - lower limb: yes
Radiating pain location - shooting, narrow band of pain into the leg: yes
Aggravating factors - end-range sidebending motions: yes
Aggravating factors - prolonged lumbar extension: yes
Leg length discrepancy: yes
Active movement tests (low back): restricted extension, restricted left side bending, restricted right side bending, pain limits extension
Repeated movement tests (low back): lumbar extension peripheralizes symptoms
Palpation - psoas major (provocation reproduces symptoms): positive
Palpation - quadratus lumborum (provocation reproduces symptoms): positive
Radicular symptoms: numbness, tingling, pain

Measures

The following measures were identified for the patient's Lumbar Spine condition:

Measure	Current (03/10/2011)	Target
Standing weight-shift (symptoms) Shifting weight from one leg to the other while standing without symptoms	Severe difficulty: 50 % weight bearing on 1 leg produces symptoms	No difficulty: Bears full weight on 1 leg without symptoms
Sitting (capacity) Ability to sit	Severe difficulty: Only able to sit < 1 hour/day	No difficulty: Sitting capability is unlimited
Standing (capacity) Ability to stand	Severe difficulty: Only able to stand < 1 hour/day	No difficulty: Standing capability is unlimited
Walking medium distances (symptoms) Walking medium distances without symptoms	Severe problem: Only able to walk < 100 yards without symptoms	No problem: Able to walk > 1000 yards without symptoms
Pain (at rest) Current level of pain	Mild pain: 1/10 to 2/10	No pain: 0/10
Pain (at worst) Highest level of pain during the last 24 hours	Severe pain: 8/10 to 9/10	No pain: 0/10
Pain (with movement) Highest level of pain while performing the most aggravating movement	Severe pain: 8/10 to 9/10	No pain: 0/10
AROM / Pain (lumbar extension) Movement / pain relations with active lumbar extension	Severe impairment: Pain during initial ranges of active lumbar extension	No impairment: No pain with active lumbar extension
AROM / Pain (lumbar flexion) Movement / pain relations with active lumbar flexion	Mild impairment: Pain only at end ranges of active lumbar flexion	No impairment: No pain with active lumbar flexion
Flexibility / Muscle length (hip extension / iliacus) Iliacus flexibility	Moderate extension flexibility deficit: -10° to 0°	Normal extension flexibility: > 10° of hip extension
Flexibility / Muscle length (hamstring / straight leg raise) Hamstring flexibility assessed using the straight leg raising test	Moderate straight leg raise flexibility deficit: 40° to 49°	Normal straight leg raise flexibility: > 60°
Strength (lumbar extensors) Lumbar extensors muscle test grade	Moderate weakness: 3/5 strength	Normal: 5/5 strength
Oswestry Low Back Pain Disability Index (ODI) Score on the Modified Oswestry Low Back Disability Index (ODI)	Severe activity limitation: ODI score 41 to 80	No activity limitation: ODI score 0 to 4

Additional Evaluative Findings

Patient also complains of periodic symptoms throughout the bilateral upper extremities were with radiculopathy.

Assessment

The examination of [REDACTED] identified low back mobility deficits associated with a current post-operative condition. Physical therapy intervention strategies designed to address these impairments will be instrumental in achieving the stated functional goals, including her ability to perform walking tasks. The additional presence of chronic pain in the involved region will likely impact the frequency of physical therapy interventions and will be addressed throughout the episode of care. Based on the examination, the patient's rehabilitation potential to achieve functional goals is excellent.

Plan of Care: Lumbar spine

Functional Goals:

1. Low back pain will improve to be able to bend below the waist and lift 10lbs intermittently for 4 hours daily for occupational activities; Timeframe: 16 weeks.

Therapist Signature(s)

Electronically signed by Kevin J Sgroi PT on 08/24/2011 10:08:33 PDT

Referral Signature

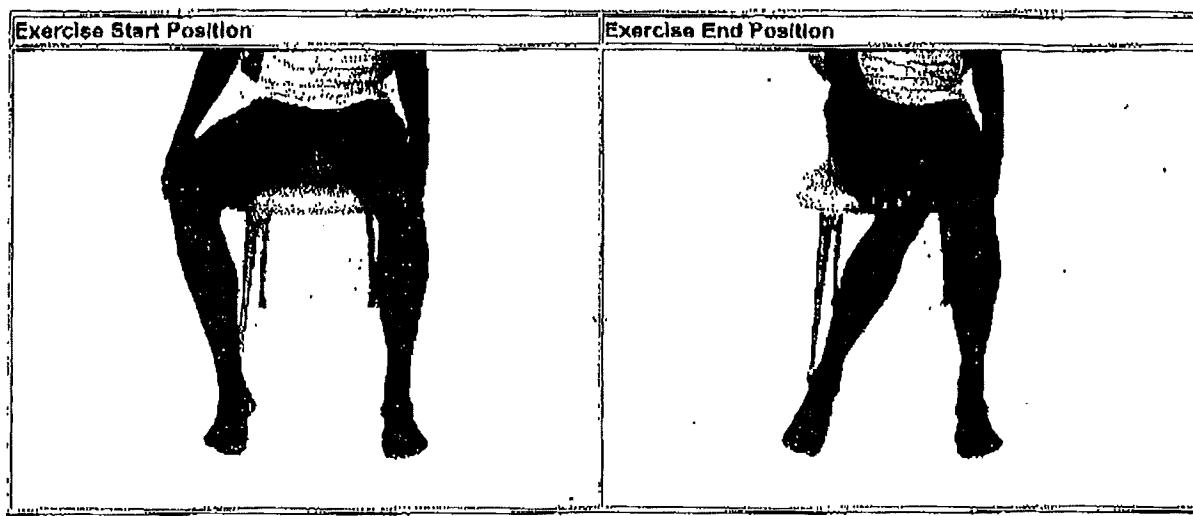
I certify and concur with the outlined Plan of Care and that this patient remains under my care.

Referral Signature:

Date:

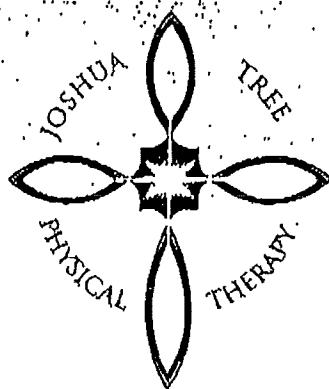
Print Name: Ronda Westcott MD

Hip Internal Rotation Stretching, Level 1



Performance Cues

- Sit at the edge of a stable chair, feet wider than shoulders-width
- Allow one knee to drop in towards the other without twisting the body
- To provide more of a stretch, apply moderate pressure to the outside of the knee that is dropped inwards



JOSHUA TREE PHYSICAL THERAPY

Initial Evaluation

Date: October 15, 2010.

Physician: Dr. Westcott

Re: [REDACTED]

Diagnosis: Mid/ Low back pain.

Dear Dr. Westcott:

Thank you for referring your patient to Joshua Tree Physical Therapy. Upon initial evaluation the following was determined.

History: The patient is a [REDACTED] female with complaints of mid and low back pain. At rest pain is rated at approximately 2/10 to 3/10 and increases to approximately 5/10 to 6/10 with activities of daily living. Patient does complain of radiating pain into the bilateral lower lower extremities. However, the patient does not complain of numbness and tingling into the bilateral lower extremities. Patient does complain of occasional headaches these are rated as moderate to severe.

PMH: Patient has been diagnosed with Chiari. Patient has undergone several surgical procedures secondary to this diagnosis. There has been a duraplasty patch surgically implanted at the base of the child's skull. She also has a lumbar shunt to enhance the flow of cerebral spinal fluid. Patient also had surgery for removal of vertebrae C1 and L3 through L5. Patient also has been diagnosed with hypercalcemic production and is taking medication HCTC for this condition.

Objective:

Active Range of Motion

Loss of Movement:

Lumbar flexion:	Moderate with severe complaints of low back pain
Lumbar extension:	Minimal with complaints of low back pain.
Lateral flexion left:	Minimal with complaints of tightness and pulling
Lateral flexion right:	Minimal with complaints of tightness and pulling
Rotation right:	None without complaints of pain
Rotation left:	None without complaints of pain

Manual Muscle Test:

Left

Right.

Quadriceps:	4/5	4+/5
Hamstrings:	4/5	4+/5
Ankle plantarflexion:	4/5	4+/5
Dorsi flexion:	4/5	4+/5
Dorsi flexion great toe:	4/5	4+/5

Objective:

AROM.

Left

Right.

Cervical flexion:	80 % of normal	
Cervical extension:	90 % of normal.	
Lateral flexion:	80 %	80 %
Rotation:	90 %	90 %
Shoulder AROM:	180°	180°

(flexion)

Observation: Patient is able to perform bilateral heel raises equally however, when performing heel raises unilaterally the patient had more difficulty raising the heel on right when compared to left.

Reflexes: Left Achilles and patella reflexes are within normal limits. Right Achilles and patella reflexes are moderately diminished.

Palpation: There are noted numerous trigger points and tonic muscle spasms throughout the cervical, thoracic, and lumbar paraspinals.

Treatment Program: The patient will receive education on proper body mechanics and posture. Treatment and modalities will include, anodyne light treatment, medical massage, neuromuscular reeducation, therapeutic laser, therapeutic exercises, and home exercise program.

Assessment:

Problem List:

- Complaints of pain at rest.
- Complaints of pain with activities of daily living.
- Tonic muscle spasms noted throughout all paraspinals.
- Decreased active range of motion cervical spine and lumbar spine.
- Complaints of constant headaches

Short-Term Goals: Four weeks

- Decrease complaints of pain at rest by 50%.
- Decrease tonic muscle spasms by 50%.
- Increase active range of motion cervical and lumbar spine to WNL.

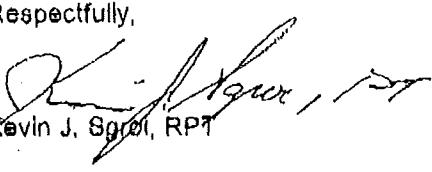
Long-term goals: Eight weeks.

- Decrease complaints of pain at rest to 0/10.
- Patient to perform activities daily living without complaints of pain.
- Decrease tonic muscle spasms by 90%.
- Patient to be independent with supervision in home exercise program.

Plan of Care: The patient will receive the above treatment program two to three times a week for up to eight weeks. The treatment program will be upgraded and modified as per physician's recommendations and as patient tolerates to achieve the above goals.

Once, again thank you for referring your patient to Joshua Tree Physical Therapy. If you have any questions or recommendations about your patient's care please contact me at your earliest convenience.

Respectfully,


Kevin J. Saylor, RPT